MAY 1961
Volume 51, Number 5

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House of Delegates
August 24, 25, 27

SCIENTIFIC SESSIONS
August 26, 27, 28, 29

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JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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STUDY 1 *Prentice, H. and Brezak, S.: J. Amer. Pod. Assn. 48:197, 1958.*

satisfactory results in 89% of cases

comments: Sardo "lends itself admirably as a pre-podiatry prophylactic in either the whirlpool bath, or as a foot soak, and as an after treatment . . ."

STUDY 2 *Steinberg, M.D.: J. Amer. Pod. Assn. 50:469, 1960.*

satisfactory results in 85% of cases

comments: Sardo "tends to restore deficient natural lipid and to prevent excessive evaporation of moisture which is an important cause of dermal dryness, scaling and itching."

STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

satisfactory results in 91% of cases

comments: "The addition of [Sardo] to the therapeutic bath prevented the drying of the skin, and its itching, commonly seen in hydrotherapy."

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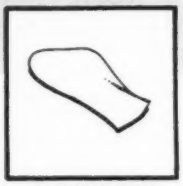

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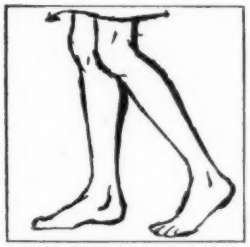
Palpating pedal pulsation at rest.

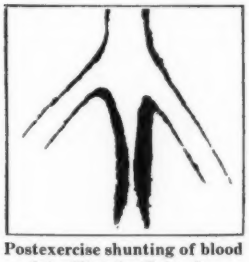
A recent report* shows that peripheral arteriosclerosis as a cause of intermittent claudication is frequently overlooked because early in the disease the patient may have adequate pedal pulses if he is examined only at rest.

In 13 patients with fatigue, aching or severe leg cramps, all of whom had readily palpable pedal pulses at rest, DeWeese* demonstrated disappearance of these pulses following sufficient exercise to bring on pain. In his test, patients ran in place at 140 to 160 steps a minute until claudication occurred. A possible explanation of this phenomenon "...is based on the shunting of the insufficient blood supply to smaller, vasodilated arteries so that weakened pulsations are observed in the larger arteries."*



Exercising patient prior to post-exercise palpation of pulses.

Based on his findings, DeWeese recommends "...that an exercise test be performed on any patient with symptoms suggestive of intermittent claudication who has palpable pedal pulses [at rest], before obstructive atherosclerosis is ruled out as a cause of the symptoms."*



Postexercise shunting of blood into dilated collaterals.

Awareness of this phenomenon, with routine performance of the exercise test, will undoubtedly help increase early diagnosis of peripheral vascular disease. Consequently, treatment can be instituted sooner, improving the likelihood of a favorable response to therapy.

*DeWeese, J. A.: New England J. Med. *262*:1214-1217 (June 16) 1960.

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References: (1) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-144 (Sept. 12) 1959. (2) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (3) Clarkson, I. S., and Le Fere, D. M.: Angiology *11*:190-192 (June) 1960.

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1. Crawford, O. B.: Anesthesiology 14:278, 1953. 2. Wiedling, S.: Xylocaine, The Pharmacological Basis For its Clinical Use, Stockholm, Almquist and Wiknell, 1959.

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1. Sokoloff, O.: A.M.A. Arch. Dermat. and Syph. *64*:754, 1951. 2. Van De Erve, J.: A.M.A. Arch. Dermat. and Syph. *68*:572, 1953. 3. Bleiberg, J.: personal communication. 4. Tobey, J.: personal communication.

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American Podiatry Council—L. J. Friedman, 1186 Broadway, New York, N. Y.
Fellows Pedic Research Society—Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

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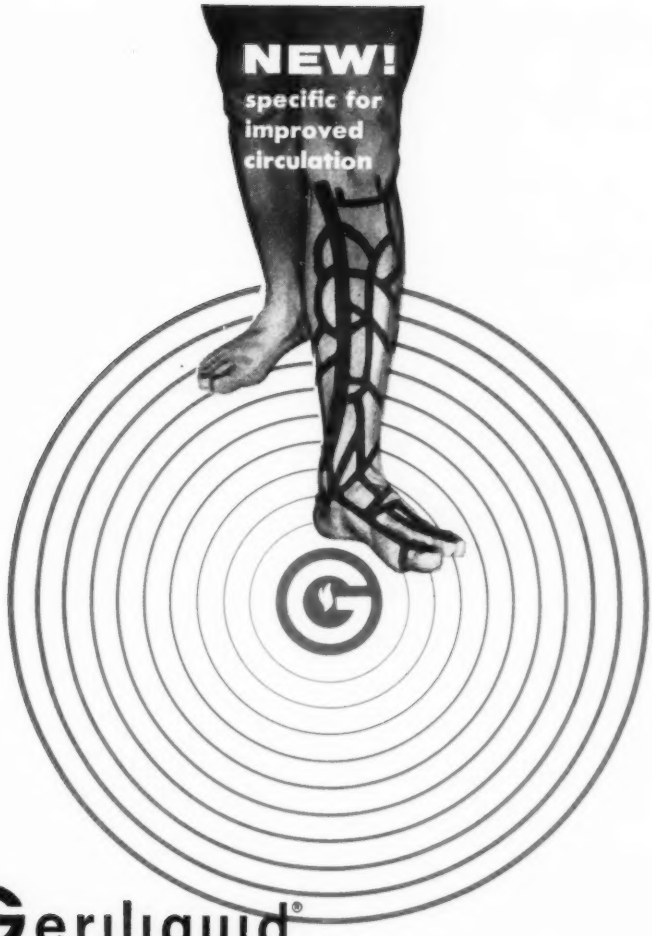
1770 Eddy Street, San Francisco, Calif.

M. J. Lewi College of Podiatry
53 East 12th Street, New York, N. Y.

Chicago College of Chiropody
1422 W. Monroe Street, Chicago, Ill.

Ohio College of Chiropody
2057 Cornell Road, Cleveland, Ohio

Illinois College of Chiropody & Foot Surgery
1327 North Clark Street, Chicago, Ill.



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The Alabama Medical Board of Examiners. **Board Secretary:** Edward E. Sealy, 39 S. Perry St., Montgomery, Ala.

Arizona
Arizona State Board of Chiropody Examiners. **Board Secretary:** Martin Snyder, D.S.C., 2629 E. Broadway, Tucson, Ariz.

Arkansas
Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California
The California Chiropody Examination Committee will meet for examination tentatively Aug. 22-23, 1961 in Los Angeles; June 20-21, 1961 in San Francisco; Oct. 17-18, 1961 in Sacramento. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

Colorado
Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut
The Connecticut Board of Examiners in Chiropody will meet for examination July 11, 12, 1961 at the State Capitol, Hartford, Conn. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware
The State Board of Chiropody Examiners of Delaware will meet for examination week of July 10, 1961 at Wilmington, Dover and Seaford, Dela. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia
The Board of Podiatry Examiners of the District of Columbia will meet for examination July 11, 12, 1961 at the Dept. of Occupation and Professions, Wash., D. C. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida
The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia
The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Hawaii
The Hawaii Podiatry Board will meet for examination July 15, 1961 in Honolulu. **Board Secretary:** Dr. R. K. Lee, P.O. Box 3378, Honolulu, Hawaii.

Idaho
The Idaho State Board of Chiropody-Podiatry will meet for reciprocity and examination, July 11-13, 1961 at the Capitol Bldg., Boise, Idaho. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois
The Illinois Chiropody Examining Committee will meet for reciprocity June 14, and examination June 14-16, 1961 at 160 No. LaSalle St., Rm. 201, Chicago, Ill. (Applications for examination must be on file at Dept. of Registration & Education, Rm. 112, State House, Springfield, Ill., at least 15 days prior to date of examination.) **Superintendent of Registration:** Fredric B. Selke, Room 112, State House, Springfield, Ill.

Indiana
The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa
The Iowa State Board of Chiropody Examiners will meet for examination June 5-7, 1961 at the State Office Bldg., Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas
The Kansas State Board of Podiatry Examiners will meet for reciprocity and examination, June 15-16, 1961, at the K. C. Med. Center, Kansas City, Kansas. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 364 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky
The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

Louisiana
Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine
The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland
The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for examination, June 20-21, 1961, at Room 33, State House, Boston, Mass. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Michigan
The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota
The Minnesota Board of Chiropody Examiners will meet for examination June 15, 16, 1961 at the State Capitol, St. Paul, Minn. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi
The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri
The Missouri State Board of Chiropody will meet April 28, 1961 in Jefferson City, Mo. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana
The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska
The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada
The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nev.

New Hampshire
The New Hampshire Board of Registration in Chiropody will meet for examination in June, 1961, at 61 Spring St., Concord N. H. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey
The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico
The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York
The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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State Board *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody will meet for examination July 15, 1961, at 1227 N. Walker St., Oklahoma City. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners will meet for examination July 19-20, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Podiatry Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, M.D., 509 Professional Bldg., Portsmouth, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia will meet for examination July 10-12, 1961 at 1800 E. Washington St., Charleston, W. Va. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners will meet for examination July 11-12, 1961, at the Public Service Auditorium, Milwaukee, Wis. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

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*Walker, M. H., Rubefacient therapy for the feet, *Journal of the American Podiatry Association*, vol. 50, Oct. 1960.

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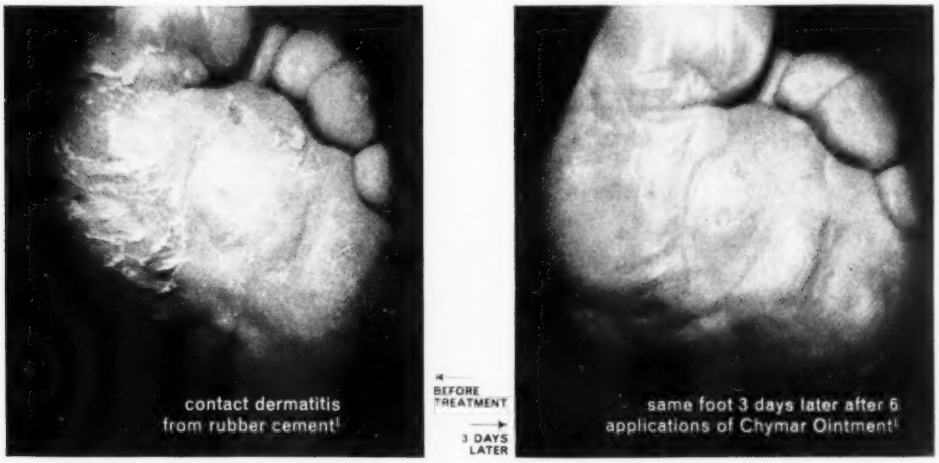

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*Tylomata, Helomata, Local Abscesses, Allergic Dermatitis, Inflamed Nail Grooves, Nail Removal, Heel Fissures, Ulcers, etc.

1. Walker, M. H.: The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions, to be published. 2. Lucas, R. D.: Current Podiatry (March) 1960. 3. Streiker, F. B.: The Use of Chymotrypsin in Foot Orthopedics. Paper Presented at the Annual Meeting, American Podiatry Association, Chicago, Illinois, August, 1960.

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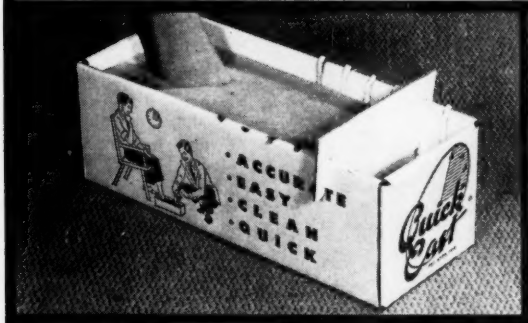

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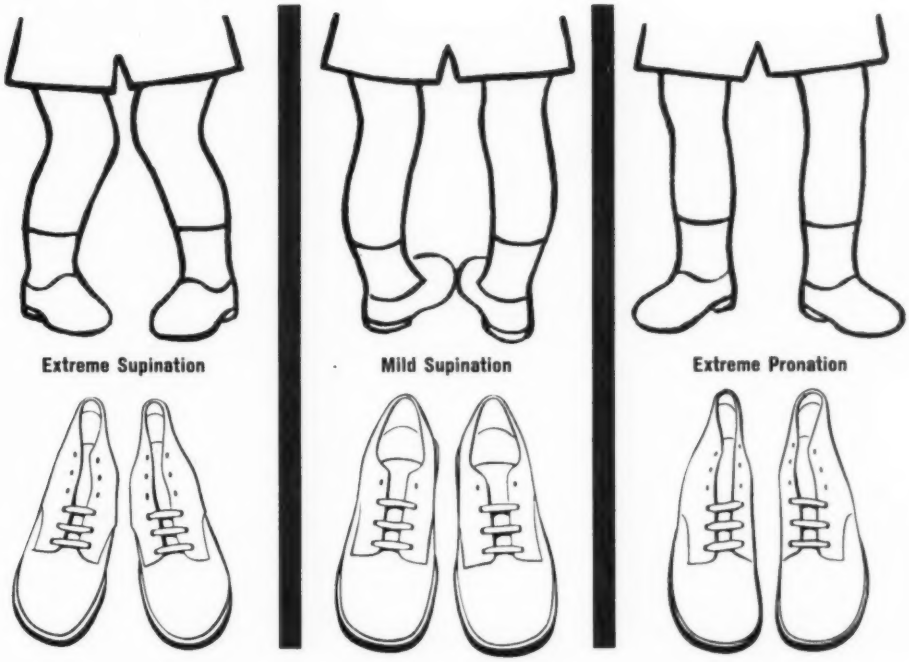

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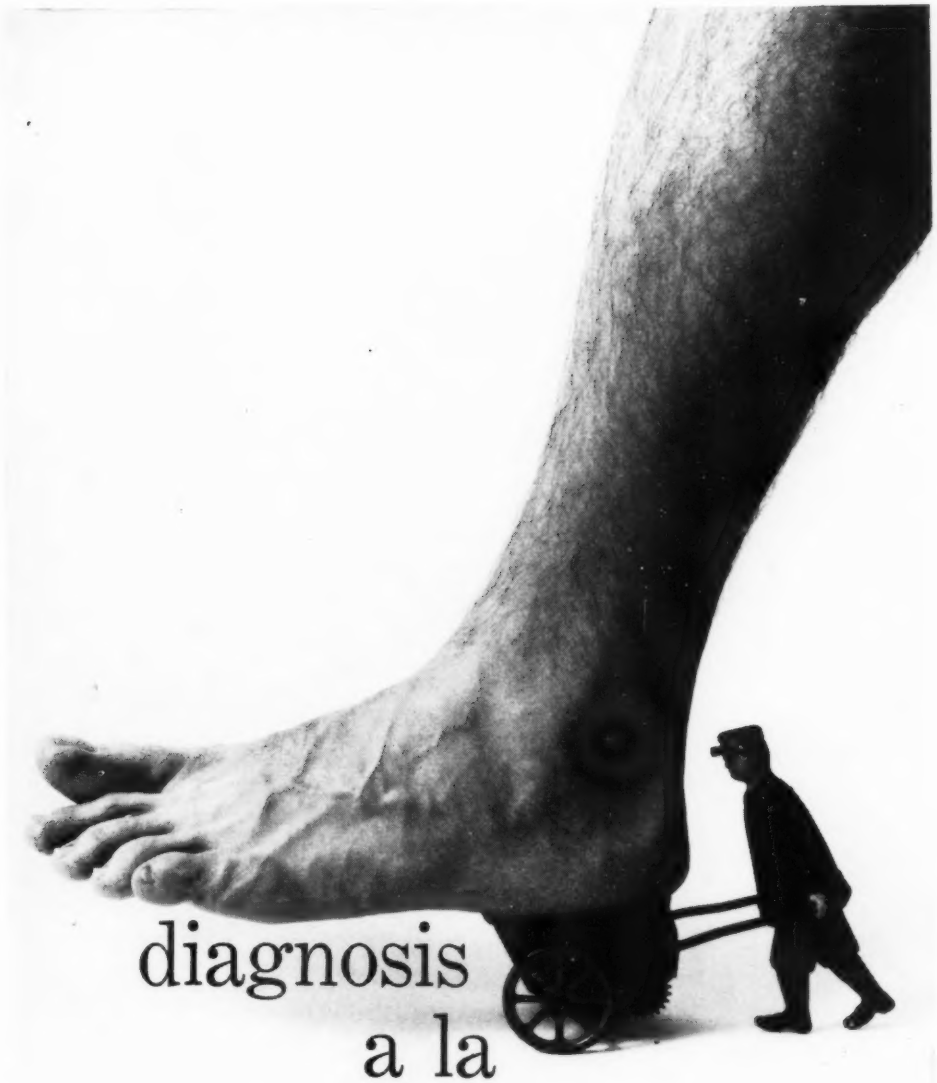

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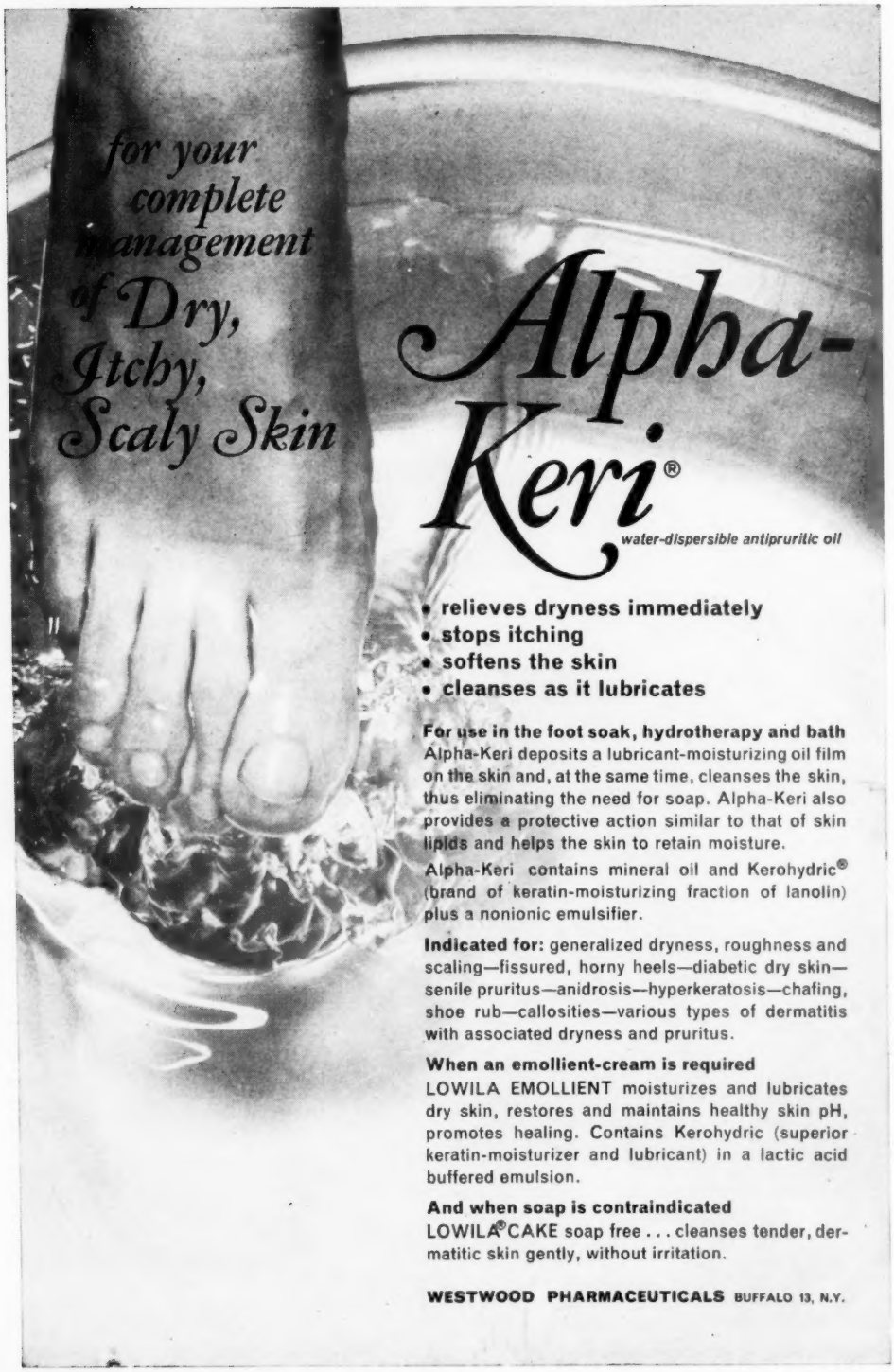
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Foreign Body Localization by Office Radiography*

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Chicago, Ill.

Most methods for the precise localization of foreign bodies require a multitude of appurtenances and specialized X-ray equipment. These may range from lead and bakelite pointer panels, localization triangles of brass, aluminum or tin or X-ray beam centering devices with fluorescent discs, to a below the couch X-ray tube using special localizing cones and fluoroscopic screens without lead glass.

While combinations of such equipment make foreign body localization relatively simple and exact, the cost of such equipment would be too great to justify its presence in the average podiatry office. This is especially true when we consider the fact that only an occasional case would require its use. Nevertheless, the podiatrist should be prepared to handle such a case when the occasion does arise. To do this he must be able to use his existing equipment to full advantage.

The description of the method whereby the podiatrist may use his standard X-ray unit without a variety of appurtenances for the localization of a foreign body is the purpose of this paper. The method used by me and which I shall discuss here is based on the principle of similar triangles. I prefer this method because it is not only simple and quick but because it also provides the operator with the exact skin position immediately over the foreign body as well as its depth. These two things, skin position and depth, must be ascertained before a method of foreign body localization can be considered practical.

Other methods which may be simpler than the method of similar triangles do not provide us with both depth and skin position. They may provide us with information about one or the other and, therefore, are not methods of choice. Typical of one such method is the one mentioned by Sante[1] wherein he paints the skin with a dilute solution of plaster of paris. The plaster hardens in the skin folds and then a flat film is taken. The radio-opaque plaster in the skin folds serves as a point of reference for the skin position over the foreign body. Simple as this method is, it only provides one of the two things necessary for foreign body localization. Further, it does not take into account distortion and image shift due to tube angulation. (Fig. 1.) Therefore, even in the matter of skin reference it is not accurate.

In using the method of similar triangles

* Paper read at the Annual Meeting of the A.P.A. held at the Drake Hotel, Chicago, Ill., 1960.
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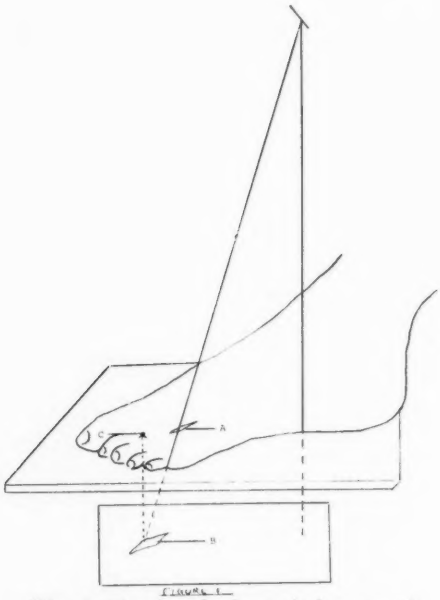

Fig. 1—Foreign body A being struck by angulated ray to produce enlarged and distorted image B which will appear to be at skin reference C.

we apply sound and proven methods based upon the laws of light propagation and geometry. Geometrically the principle is this: The base of one triangle is to the base of a second triangle as the altitude of the first triangle is to the altitude of the second triangle. When we know three of these values we can compute the fourth. From the standpoint of the propagation of light we know that the farther an object is from a screen (i.e. the film) the more diffuse the shadow will be, and the less complete its edges when the light source is larger than the object. Even in the case where the object is larger than the light source, the shadow will not have sharp edges. To carry this one step further, if we shift the light source so that it is not directly in line with the object, the shadow will shift in a direction opposite to that of the light source.[2] (Fig. 2.)

The practical application of these principles in foreign body localization is really quite simple. With very little practice, the entire procedure which I am about to set forth should not take more than 6 minutes to accomplish. This does not include time taken for the development of the film.

As would be done with any technique, a flat film is taken first in order to determine the presence of the foreign body and its approximate location. Using this film as a guide, a small metallic cross with one arm longer than the other is taped to the skin over the assumed position of the foreign body. The cross may be fashioned from a paper clip. The long arm of the cross should lie perpendicular to the long axis of the foreign body and should also point in the direction of the tube shift.

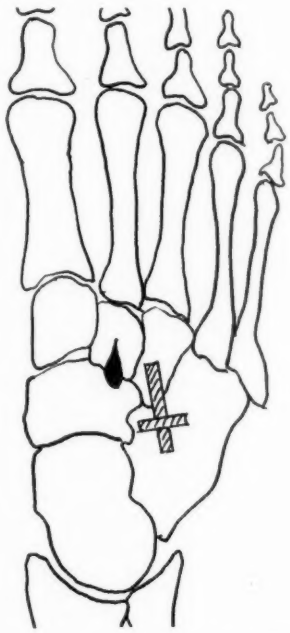

Fig. 2—View this diagram with the right eye only, then with the left eye only, in rapid succession. Note how the image shifts to the left when viewed with the right eye and to the right when viewed through the left eye.

The X-ray tube is then positioned over the center of the cross and one-half of the standard exposure is made. For example, if exposure factors for the area you wish to X-ray call for the film to be taken at a 32-inch distance using 55 KV and 20 Ma at 2 seconds, merely expose the film for 1 second. Now shift the tube a measured distance along the long arm of the cross, usually about 6 centimeters. The second half of the

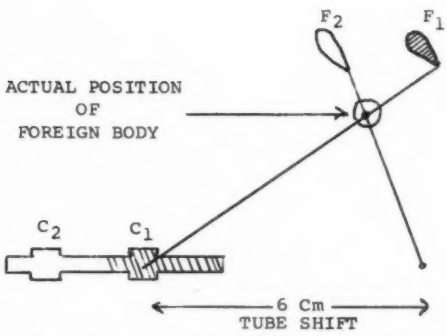

Fig. 3—C_1 first shadow of the cross. C_2 second shadow of the cross. F_1 first shadow of the foreign body. F_2 second shadow of the foreign body.

exposure is then made from this second position.

With the cross left taped to the patient's skin the film is then developed. When the film is fully processed, four shadows will be visible over the bones of the area. There will be two shadows of the foreign body and two shadows of the cross. We can now proceed to locate the exact skin position of the foreign body.

Place the film just taken on a flat surface and with a white marking pencil, draw a line from the shadow of the first cross (it will be slightly darker than the shadow of the second cross) to the first shadow of the foreign body. Draw a second line from a point 6 centimeters along the long arm of the first cross (this is a distance equal to the tube shift) to the second shadow of the foreign body. These two lines will bisect. The point at which they cross is the exact anatomical position of the foreign body. (Fig. 3.)

Now, with the use of a small probe, punch a hole in the film at the exact location of the foreign body. The film is then placed on the patient's foot so that the first shadow of the cross lies directly over the cross taped to the skin. Care should be taken so that all anatomical landmarks are in line. With a cotton applicator dipped in merthiolate or any other dye, a mark is made on the skin through the hole in the film. The foreign body will lie directly beneath this mark. The cross taped to the skin can now be removed and the patient can be allowed to relax while the depth of the foreign body is determined.

Using this same film, we carefully measure the distance between the two shadows of the cross and the distance between the two shadows of the foreign body. These distances provide us with the bases of our similar triangles. The altitude of the triangle is the tube-to-film distance given earlier as 32 inches. In order to insure accuracy, the distances should be measured in centimeters because in actual practice the shifts of the shadow will be small, and accurate measurement in inches will be difficult.

From our measurements we can first determine the height of the triangle that has the cross taped to the skin as the apex and the shadows of the cross as its base. Then we can determine the altitude of the triangle

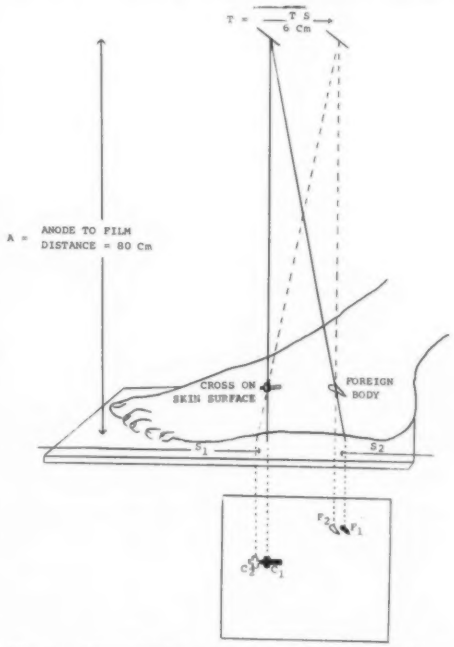

Fig. 4 — Computation of Depth of Foreign Body
S_1 = Shadow shift of cross = 4 Cm.
S_2 = Shadow shift of foreign body = 2 Cm.
A = Anode to film distance = 80 Cm.
T = Tube shift = 6 Cm.

Cross to film distance $= \frac{A \times S_1}{T + S_1} = \frac{80 \times 4}{6 + 4} = 32$ Cm.

Foreign body to film distance $= \frac{A \times S_2}{T + S_2} = \frac{80 \times 2}{6 + 2} = 20$ Cm.

Depth of foreign body = 32 − 20 = 12 Cm.

that has the foreign body as the apex and its shadows as the base. This second triangle will be lower than the first since its apex is at some point below the skin surface. The exact distance below the skin surface is found by substracting the height of the second triangle from the height of the first.

The method by which these values are found is illustrated in Fig. 4. This composite diagram uses rather large shadow shifts in order to illustrate the method more clearly. It should be understood that in most instances a foreign body depth of 3 or 4 centimeters would be more plausible than one of 12 centimeters.

In the equation depicted in Fig. 4, A represents the anode to film distance measured in centimeters. S_1 represents the distance measured between the shadows of the cross. S_2 the distance between the shadows of the foreign body. T is the distance the tube was shifted for the two exposures. The equation for determining the exact depth of a foreign body from the skin surface would be as follows:

$$\frac{A \times S_1}{T + S_1} - \frac{A \times S_2}{T + S_2} = \text{Depth of foreign body}$$

Through the use of the method I have set forth here I believe that it is possible to take all of the guesswork out of foreign body localization without the need for expensive equipment. Further it also serves to spare our patients needless probing and subsequent discomfort.

3344 W. Peterson Ave.

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Fifth Toe Fractures

Irving H. Block, Pod.D., F.A.S.C.R.
Miami Beach, Fla.

A TRAUMATIC lesion of the foot seen quite often in practice is the fracture of the fifth toe. It is especially frequent in the summertime, or in climates that are conducive to little or no protective footgear. Perhaps the most frequent injury to the small digit occurs when one gets out of bed at night in his bare feet and bumps his toe against a piece of furniture. This has been called by many, the "bedroom" fracture. The distal end of the toe is stubbed and the shock is transmitted to the proximal or middle phalanx where the fracture occurs. When an object falls directly on the toe and shoe protection is inadequate, a fracture may result. Toe injuries also occur in sports, at work and in vehicular accidents. From stubbing or direct injury to the toe, several types of fracture may occur singly or multiplely.

Differentiation roentgenologically between the kinds of fracture is important since treatment and prognosis depend on this knowledge. Fifth toe fractures should not all be treated similarly, and X-rays are a necessary guide. Occasionally the clinical picture presents exaggerated symptoms. In these cases the picture is helpful in determining the extent of soft tissue damage.

Of the three phalanges, the middle and distal phalanges may be fused, with no joint space, and appear as a single tapered bone. The phalanges are long bones with a head, neck, shaft and base. The ossification centers are one each for the shaft and base. Fusion occurs between the 16th and 20th years. The muscular insertions are numerous. The proximal phalanx receives the attachments of the Abductor and Flexor digiti quinti and third Plantar Interosseus. The middle phalanx receives the Extensor digitorum longus and brevis and the Flexor digitorum brevis and Lumbricales, and the distal phalanx the Flexor digitorum and Extensor digitorum longus and brevis.

Collateral and plantar ligaments connect the phalanges with the aid of the extensor tendons, dorsally. The joints are of the hinged type, have a capsule and are often protected by a small bursa. The joint space is bounded anteriorly and posteriorly by radiolucent cartilage. Supernumerary bones are found rarely in or about the interphalangeal joints, but are present less rarely under the fifth metatarsal head. The digital branch of the lateral plantar nerve and the sural nerve innervate the toe and the lateral plantar artery with its digital branches provide the blood supply.

A fracture is defined as a break in the continuity of a bone. When a fracture occurs, blood and exudate collects between the fracture ends. This becomes granulation tissue which is replaced by osteoid tissue, bone callus. Calcium salts are deposited as union is completed. Excessive bone callus is removed by osteoclasts.

However, when bone is not properly splinted or immobilized, excess exudate may result in fibrous union which delays healing. In the fifth toe this frequently results in deformity and bursae and helomata develop.

Fifth toe fractures are of several types. They may be simple or compound, single or multiple, and traumatic or pathologic. Perhaps the most common type of fracture seen in our offices as a result of bumping the end of the toe, is the comminuted fracture where the bone is shattered. It is further complicated if the injury includes adjacent parts such as joints and capsule. If the break extends entirely through the bone it is complete. If it is broken in more than one place, it is multiple. Greenstick fractures are rare in fifth toe injuries. (In 18 years we have seen only two, one in a 13-year-old boy and the other in a 17-year-old girl. In both cases the entire digit was also dislocated at the metatarsophalangeal joint.) Where the fragments are compressed into each other it is impacted. Where the fracture line in the shaft is twisted, it is spiral. A more common type is the oblique fracture where the break runs slanting through the shaft (a twist is frequently present).

Mechanically the fracture occurs because the middle or proximal phalanges are bent much beyond their normal limit of flexibility, rupturing the cortex, tearing the periosteum, and, if forceful enough, pulling the fragments apart. If the fracture is complete, there will likely be an overriding of segments with a possibility of its becoming compound.

Simple fractures can sometimes be overlooked by both the patient and the doctor. After the initial pain of the injury subsides, only a faint burning sensation or discomfort may remain. It is not until a shoe is worn that further pain and swelling occur. This will be within several hours, but not infrequently as late as the 10th day when the accident is often forgotten.

Clinically we find swelling, discoloration of the toe and web, and sometimes crepitus on manipulation. With more extensive trauma we may find spasm of the Lumbricales and Interossei muscles causing a spreading of the fourth and fifth toes, and a pronounced spasm of the dorsal tendons. Pain may radiate beyond the cuboid and ankle. The extensor muscles may become so spastic that reduction of the fracture may become difficult to achieve without local anesthesia. A frequent complication of these fractures is a partial or complete dislocation of the metatarsophalangeal or interphalangeal joints. The patient will complain of pain, the severity of which depends upon the type of break, the period elapsed since the injury, emotional quotient of the patient and complications.

Following the clinical examination, radiographs are taken for a wet reading within a few minutes. This should be a routine procedure. However, when there is little pain or subjective symptoms, it may be more difficult for the patient to accept the fact that X-rays are necessary. The doctor may decide against taking films when the symptoms are mild. Thus, occasionally a fracture will be overlooked. It is a good rule to X-ray all injuries for legal purposes and so that insurance claims may be satisfied.

We feel that it is generally helpful to let

the patients see the films, of course with reservation as to their age and degree of understanding. We make this a simple identification. Where injuries are more complex, however, we do not do this. For those patients who need the films because they are leaving the city, or because they live far from the office and further care would be difficult, it is advisable to expose two plates at the same time. We keep the films in our files and only send them out upon written request and signed authorization from the patient, naming the insurance company, attorney or doctor wanting the records.

Although only two projections are usually sufficient to properly view fifth toe fractures, we believe that a more precise identification should be made using three exposures. These are taken on a divided 10 x 12 film, and where time has elapsed after an injury, or when a different diagnosis may be necessary, a fourth view is taken of the other foot. We use the standard weightbearing platform with the patient sitting on a chair, foot relaxed, nonweightbearing, and find the dorsoplantar, oblique and lateral, the views of choice.

Where swelling is pronounced and toe separation is desired, as in the lateral view, we hold the toes in the proper position during exposure with long thin strings. This permits good stability, little movement and safety to the operator. As far as possible we avoid unnecessary radiation by employing the described strings and stand at least 8 feet from the X-ray tube, using a minimum of time.

We employ regular nonscreen film. Markers are used to identify name or file number, our name and city, the date, right and left, and view, e.g. DP.

Treatment depends upon the type of fracture and the severity of the symptoms. We apply ice packs, rest and immobilization with subsequent reduction if the fracture is recent. Care is given for lacerations, control of infection and pain. Where dislocation and spasm are a complication, it may be necessary to infiltrate the joint and belly of the Extensor digitorum brevis in order to reduce this condition.

If the fracture is simple and there is little or no displacement, immobilization with adhesive tape, using the third and fourth toes as splints is sufficient. A small, soft roll is adhered to the underside of the involved toe. The strapping is carried well down to about the base of the fifth metatarsal, locking the metatarsophalangeal joint securely. A regular shoe, usually an old one, is probably the most comfortable to be worn, once the side has been sliced.

Where there is overriding of the segments, and reduction is necessary, the bone is carefully pulled into its proper position and traction increased until the resistance is overcome and the toe is straight. Where chips are present, usually at the base or head of the bone, it may only be possible to partially reduce the fracture and then complete the positioning with a traction splint, using a small metal or plastic strip, bent over the toe, binding it to the base of the toe with a few circular turns of tape, and then taping the toe, distally, to the splint. With this device it may not be necessary to cut away the entire front of the shoe.

When fragmentation extends into a joint or close to the skin it may be necessary to do an open reduction, and remove the offending chips of bone, or pin the bone if the fragments are poorly aligned. When the fracture is compound, the lacerated tissue is treated as a wound so that infection is minimized and then immobilized.

Redressings are done weekly, care always being taken to prevent skin breakdown and, where allergy to adhesive is present, protective dressings are applied covered with self-adhering gauze. Patients can usually be dismissed in 4 to 6 weeks. Where edema and chronic phlebitis are a factor, celastic half-shells held in place by circular elastic bandages are used. These can be worn for a month or more and easily removed when physiotherapy is applied. In multiple fractures where infection is present, after debridement, mild boric acid soaks are applied with the patient in bed. An antibiotic should be administered if the infection is severe and lymphatic involvement present. Tetanus booster shots should be given in

these cases and if antitoxin is required, we refer the patient to his physician or a local hospital. After the third week, 10 minutes of infrared is given. If edema and pain are still present, hydrotherapy with infrared is prescribed every other day. We have not found any benefit from ultrasound in fractures.

When the patient is discharged, a ½-inch-wide strip of adhesive, approximately 5 inches long, is applied around the fourth and fifth toes. Instructions are given to change this sling about every 4 or 5 days for about 2 weeks. This has proven most satisfactory in maintaining additional stability and comfort for the toes, and is a safeguard against further injury while the callus is still not fully organized, and the supporting structures of the toes are still stretched and weak.

The prognosis for the usual fifth toe fracture is good. Healing is uneventful and a regular shoe may be worn within a month to 6 weeks. However, fancy dress shoes are contraindicated for at least 2 months. In the small number of severe cases, the prognosis will vary and the healing time may be extended.

A desirable sequel that we have found to occur at times, especially in the "bedroom" fractures, is the disappearance of a heloma that has been present for some time. We could expect a diminution of the growth because of the absence of friction during the time of immobilization and lessening of shoe pressure. Often we may get a better position of the toe and the corn stays away for months and even longer. Conversely, when the simple fractures are neglected and remain untreated, we may anticipate arthritic changes, intermittent pain and rheumatic discomfort occurring even years later.

Conclusion

Never underestimate a fifth toe injury. Make a proper diagnosis with radiograms. Immediate and adequate care will yield a better prognosis.

One Lincoln Road Bldg.

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Foreign Body Removal Utilizing an Electromagnetic Device

Milton D. Roven, Pod.D., F.A.P.
Brooklyn, N. Y.

THE importance of X-ray examination to rule out a foreign body, even though a very thorough history gave no clue as to its existence, is shown in this case report.

A 60-year-old female presented a painful, hot, edematous right foot. There was exquisite tenderness in the area of the plantar surface, shafts of the second and third metatarsals, and the heat and redness suggested a cellulitis. There was no history of stepping on a foreign body or even going barefooted.

A routine X-ray examination showed two-thirds of a needle between the second and third metatarsals (Fig. 1).

The patient had no recollection whatever of a needle penetrating her slipper or her foot.

Patient was referred for surgery and the needle removed under general anesthesia, utilizing the Berman metal locator®[1]. This operates on the principle of electromagnetic induction, employing a thin-pointed probe for detection of the foreign body.

Localization is based on the indications of a meter and a small loudspeaker operating simultaneously. Both of these are on the panel of the electronic amplifier to which the probe is connected. When the instrument is set for operation, it is adjusted to

®[1] Berman Laboratories, Ozone Park, N. Y.

Fig. 1—Several views of a needle embedded in foot.

give a sound of uniform pitch which remains essentially unchanged until the probe approaches close to a metallic foreign body, when the meter reading and the tone pitch both rise sharply. As the probe passes beyond the site of the foreign body, the meter reading and the tone pitch both drop. The point on the surface where the peak indication occurs, marks the closest approach to the foreign body. Intervening tissue does not interfere in the localization.

When used within the incision, the probe is covered with a specially designed jacket of thin surgical rubber which can be sterilized by boiling or autoclaving. Nonresponsive retractors supplied with the instrument are used for retraction.

After locating the closest approach to the foreign body, a transverse semi-elliptical incision was made extending from the distal third of the second metatarsal shaft to the fourth metatarsal shaft. The margins of the skin were undermined and reflected. An Allis clamp was placed into the wound and a sound of metal was apparent whereupon the needle was grasped and removed in one piece. The skin was closed with five interrupted 0000 dermal sutures and the patient made an uneventful recovery.

Many instances have been recorded of the migration of a needle. In less than 3 hours a sewing needle wandered from a wound, a hand's breadth above the elbow, to the forearm[1]. Nestos[2] reported a case in which a needle was swallowed and 10 days later protruded through the skin 3 inches below the ensiform cartilage and 1 inch to the right of the median line. Meyer-Pantin[3] collected reports of 12 cases in which a needle entered the heart and was the cause of death, and 10 cases in which a needle was unexpectedly found in the heart at autopsy. Hinton[4] reports a fatal case in which a needle used to aspirate the chest, accidentally broke off. After a 7-day interval, thoracotomy was done without an attempt to remove the needle. Three hours afterward, the patient died suddenly and at postmortem examination the needle was found piercing the heart. In a case reported by Rea and Hoover[5], a needle apparently passed from the left foot to the heart in 4 years. Death was sudden and postmortem examination disclosed that the needle had penetrated the left ventricle.

In Jacobaeus' case[6], a migrating needle caused spontaneous pneumothorax. Martin[7] cut down upon a needle which had shown by X-ray the day before to be in the palm of the hand. It was finally found under the annular ligament, 4 inches away. De Tarnowsky[8] reports a case in which two sewing needles which had been pushed through the epigastrium 15 years previously were removed from the falciform ligament and the right lobe of the liver, respectively.

Rees[9] has reported an ingenious method for the removal of foreign bodies, such as needles, thorns and splinters, which break off under the dermis at nearly right angles to the surface of the skin. Difficulty in removing such objects is often encountered because the incision may pass on one side or

the other of the foreign body and it is difficult to determine on which side it lies. Rees suggests that incision be made only through the skin and the skin then undercut on all sides for a distance of about ¼ inch. In this way, the fatty tissue in which the foreign body lies is not disturbed and, by pressure upon the sides of the wound, the fat may be extruded into the wound and bear the foreign body with it. He advises excision of the fat containing the foreogn body rather than simply removing the object. When the foreign body projects at the skin surface, he makes an elliptical incision centering on the wound of entrance. The removal of the elliptical piece of skin in the center then shows the exact location of the foreign body, which may be removed as described above. In such exploration for foreign material, he advises that if local anesthesia is used, it is to be deposited not as an infiltration but as a field block around the area in which the foreign body is believed to be. In this way, the thickening of the tissues by edema is avoided.

Summary

The value of X-ray examination and an electromagnetic device for location of metallic foreign bodies has been described. The possible migration of some foreign bodies has been cited.

1900 Albemarle Rd.

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Report on a Study of Nylidrin HCl and Vitamin E In the Treatment of Peripheral Vascular Disease*

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Cleveland, Ohio

THIS paper is a report of the clinical investigation carried on at the Foot Clinic of the Ohio College of Chiropody into the effects of Vitamin E and Nylidrin HCl used singly and in combination in the treatment of intermittent claudication, numbness or paresthesia, ischemic and diabetic ulcerations, thromboangiitis obliterans, thrombophlebitis, cold feet, frostbite, nocturnal cramping and other vascular disturbances of the extremities which could be benefited by an increase in peripheral blood circulation.

Peripheral vascular disease is a problem of prime interest to the foot specialist, as a member of the medical health team, since we see these problems daily in our practice.

In this study, Vitamin E was supplied as D, Alpha-tocopherol acetate‡ in a water-soluble form, for more rapid and complete absorption and better utilization by the body. Each capsule was equivalent in biological activity to 100 international units.

A few of the functions attributed to Vitamin E are:

1. Prevents hemolysis of erythrocytes
2. Aids muscle metabolism
3. Aids tissue utilization of oxygen
4. Decreases the insulin requirement in some diabetics
5. Increases prophylaxis of thromboembolism
6. Acts as a vasodilator and improves collateral circulation
7. Plays an important part in fat metabolism

* Presented at the Annual Meeting of the A.P.A. held at the Drake Hotel, Chicago, Ill., 1960.

† Clinician, Cleveland Foot Clinic, Ohio College of Chiropody.

‡ Supplied as Aquasol E Capsule, 100 Int. Units by U. S. Vitamin Corp., New York, N. Y.

Nylidrin HCl is a pharmacologically active sympathomimetic-like drug, Arlidin®[1], and increases blood flow to the extremities by a unique pharmacologic action: 1) Dilates predominantly the small arterial vessels in skeletal muscles. 2) Increases cardiac output by increasing minute stroke volume. Preliminary steps before instituting therapy were: 1) History of the selected patients. (a) Patients with a history of hyperthyroidism were not included in this study since both Arlidin and Vitamin E should be used with caution in these patients. 2) Physical examination, (a) Vascular examination, (b) Pulses, blood pressure and oscillometric determinations. 3) Laboratory work-up, (a) Routine urinalysis, complete blood count, blood sugar determination, cholesterol level and fatty acid content. These laboratory procedures were repeated during the early stages of the project to determine if any changes were occurring in these values during therapy. No changes were noted. Therefore they were no longer performed routinely.

The following was a basic dosage schedule: 1) Vitamin E (Aquasol E)—treatment was instituted with 600 Int. Units per day for a period of 2 or 3 weeks, then 300 Int. Units a day for an additional 2 or 3 weeks, or longer if indicated for patients on Vitamin E alone. The capsules were to be taken in daily divided doses ½ hour before meals due to the fact that the tocopherols tend to be destroyed in the presence of free fatty acid; hence they are best administered on an empty stomach, ½ hour or more before meals. Iron compounds were not to be taken concurrently with the Vitamin E as they inhibit the action of the Vitamin E. 2) Nylidrin HCl. therapy was instituted with one 6 mg. tablet taken twice daily. The dosage was slowly increased until the desired therapeutic effect was obtained. The maximum dosage required in this study was one tablet 4 times a day. In "night leg cramps" the dosage was one tablet upon retiring.

®[1]Supplied as Arlidin Tablets by U. S. Vitamin & Pharmaceutical Corp., New York 17, N. Y.

Response by Groups Under Therapy

Group I—Nylidrin HCl.

This group included 25 cases with signs and symptoms of peripheral vascular disease. These patients presented such signs and symptoms, singly or in combination, as intermittent claudication, night cramps, numbness or paresthesia, cold feet, diabetic and ischemic ulcerations. Seven presented a single symptom, while 18 presented two or more symptoms of peripheral vascular disease.

With only two exceptions, everyone in this group reported improvement in varying lengths of time after the therapy was instituted. The time interval before improvement varied between 2 and 5 days. Five patients in this group reported slight improvement and 18 were much improved after dosage had been adjusted to their needs.

Objective findings disclosed an increase in the oscillometric readings in 40 percent of the cases. Subjectively, the patients noted a sense of well-being with the increased peripheral blood flow, and there was also an increase in the ability to walk farther in comfort.

One patient in this group noted side effects of nervousness and palpitation occurring with the oral administration at a dosage of four tablets a day. However, when this dosage was reduced to three tablets a day with meals, the untoward effects did not occur and the therapeutic response was maintained.

Group II—Vitamin E and Arlidin

This group also includes 25 patients presenting symptoms of peripheral vascular disease comparable to those included in Group I, i.e., varicose ulcer, ischemic ulcer, thrombophlebitis, cold feet, intermittent claudication, nocturnal cramping, numbness and burning of the feet. Eleven patients reported only one symptom and 14 reported two or more symptoms. Of the 25 cases reported in this group, 16 were much improved, 6 slightly improved and 3 cases remained the same—time interval before improvement, 3 to 10 days.

TABLE I
Results of Therapy by Groups

Group*	Total Patients	Much Improved	Slightly Improved	Not Improved	Worse
I	25	18	5	2	–
II	25	16	6	3	–
III	25	8	11	5	1
IV	15	–	1	9	5
Total	90	42	23	19	6

* Group I: Arlidin alone
II: Vitamin E and Arlidin
III: Vitamin E alone
IV: Control

In this group, findings showed increased oscillometric readings, 30 percent of the cases showing improvement. There was little or no change in pulses or blood pressure in this or the other groups. Subjective reports from the patients with improvements disclosed the same sense of well-being. Increased ability to walk farther in comfort was noted by those presenting symptoms of intermittent claudication.

A diabetic ulcer in this group responded early and healing was complete in 6 weeks. It is interesting to note that a previous ulcer at the same location in this patient required 4 months of treatment when no vasodilator was administered. One case in this group, diagnosed as thromboangiitis obliterans, showed no improvement until he followed instructions to discontinue smoking.

Group III—Aquasol E

The symptoms of the patients included in this group compared with those of the previous two groups, including burning feet, cold feet, diabetic ulcer, varicose ulcer, intermittent claudication, frostbite, numbness and nocturnal cramping of the feet and legs. Ten patients reported one symptom of peripheral vascular disease while the remainder of the patients in this group reported two or more symptoms. Of the 25 cases in this group, 8 were much improved after the 6 to 8 week period of therapy with Aquasol E. Eleven showed slight improvement. Of those remaining, five noted no improvement and one case became worse. In this case the problem was one of a diabetic female, 78 years of age, with several ulcerations on the feet of long duration. On oral administration of Vitamin E, this patient developed gastric symptoms and a dermatitis medicamentosa. However, this patient was under treatment with other drugs; therefore, one cannot be sure that the reaction was due to the Vitamin E. The time interval for improvement was 10 days to 6 weeks.

Two other effects were noted in those patients on Vitamin E alone; one, a diabetic female, was found to have a decrease in her insulin requirement and the other patient felt that she was gaining weight while under the Vitamin E therapy. In both of these cases, improvement was noted in their symptoms.

It is to be noted that response in those patients treated with Aquasol E was not as rapid as the response of those in Groups I and II. However, when relief from the symptoms or condition was obtained, it appeared to be of a more lasting nature when the therapy was temporarily interrupted.

According to Schreiber, one should allow 1 to 3 months for a clinical response with Vitamin E therapy and following the correct tailoring of the dosage, one should continue with a maintenance dosage indefinitely.

Group IV—Control Group

The control group consisted of 15 patients presenting the same symptoms of peripheral vascular disease as were previously mentioned with Groups I, II and III. These patients were placed on a dosage of two placebos daily and were maintained on this dosage until their therapeutic response was noted. In consideration of the welfare of these patients placed in this control group, when a case began deteriorating, the patients were placed on a positive ther-

apeutic regimen. Of the 15 patients placed in this group, only one felt that there had been any improvement and this was slight. Nine cases remained the same and five of the cases became worse.

Summary

Nylidrin HCl (Arlidin) and Vitamin E (Alpha-tocopherol—Aquasol E) have been utilized both singly and in combination in a clinical investigation into their therapeutic effects in the treatment of peripheral vascular disease and its symptoms. In Group I, patients treated with Arlidin, 92 percent obtained complete relief or improvement from their symptoms. Group II, patients given Vitamin E and Arlidin, showed 88 percent improvement and Group III, patients treated with Vitamin E alone, showed improvement in 76 percent of the cases.

It does not appear that Vitamin E (Aquasol E), when given in combination with Nylidrin HCl (Arlidin), has any appreciable effect towards hastening or enhancing the clinical response of Nylidrin.

Vitamin E (Aquasol E) singly appears to have definite value in the treatment of the symptoms of peripheral vascular disease. However, the clinical response is less rapid in onset and it should be considered as longer term therapy.

The author wishes to gratefully acknowledge the aid and assistance in the carrying out of this study of Dr. M. Pomerantz, Dean, Ohio College of Chiropody; Dr. T. J. Fletcher, Director of Clinics; Dr. Raymond Locke, Research Director, Zaccharian Research Society.

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Necessity for Improved Foot Health Services in Schools

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THE problem of poor foot health throughout the United States has been explored by community health workers for the past 3 decades. Survey after survey has consistently revealed that from 65 percent (boys) to 80 percent (girls) the youth of this country exhibit symptoms of foot disabilities by the age of 16.

The Board of Education of the City of New York, under the direction of Dr. Frank O'Brien[1], conducted a survey which revealed that one-fifth of a group of 20,000 elementary and high school pupils had advanced foot problems that required professional rehabilitative care. Only one-fifth of these 20,000 pupils showed no overt foot ailments. The remainder had minor easily correctible foot difficulties.

Table I lists some recent school foot examinations. The results of these examinations conformed, in the main, with those previously mentioned in New York City.

A survey is initiated when an individual who is interested in the problem brings the question to the attention of the school board. The school then coordinates its forces with the school health personnel, the superintendent of schools, the county medical society, the county podiatry society, and so forth. When the individual and committees concerned have duly considered and approved the project the survey is launched. Teachers, school nurses and all concerned join forces in educating the pupils to the idea of good foot health. The pupils are given literature which advances ideas of

TABLE I
Recent School Foot Examinations

Year	Place	No. of Students Examined	Grade
1950	Norwich, N. Y.[2]	1,738	786 elem. 306 Jr. High 676 High School
1951	Tucson, Ariz.[3]	1,589	5th grade
1952	Valley Stream, N. Y.[4]	1,000	elementary
1953	Lubbock, Tex.[5]	1,703	elementary
1947-54	Illinois[6]	7,000	

good foot health, films on foot health are exhibited and teachers give talks on the subject as a preliminary to the actual foot examinations. The examination is usually carried out in the school gymnasium by a podiatrist or physician. Individual reports are made outlining specific findings which the child presents to a parent or guardian for signature. Those with more than minor difficulties are advised to seek further professional advice and treatment.

Results of such surveys reveal for example that "out of 1703 students examined there were 142 cases of excrescences, 24 cases of warts, 362 cases of dermatologic abnormalities, 57 cases of ingrowing toenails, 286 cases of poor foot hygiene, 149 cases of excessive perspiration, 129 cases of low arches, 316 cases of foot pronation, 340 cases of defective posture and 569 cases of poorly chosen types of shoes.[7]" It is gratifying to report that school, community and individuals in Lubbock recognized the value of the project so that "students and parents became foot conscious . . . school health authorities feel that the foot health survey has been very beneficial in instructing students in the proper care of the feet and that good health and good posture depend upon sound foot structure and care.[8]"

In 1842 Horace Mann suggested[9] that health values should be taught in schools. His ideas were not executed for many years. In the area of foot health, three states, California, Massachusetts and Rhode Island, have statutes requiring compulsory foot examinations.[10] Other states, about 20 in number, are considering similar legislation. As in other areas of preventive medicine, early investigation into foot health can uncover incipient problems so that less therapy will be necessary and better results can be obtained.

General principles of health education can be applied advantageously in the area of foot health. For example, teachers should be made aware of proper foot hygiene and attempt to transmit this awareness as they already do with regard to teeth and mouth, to cite one instance. Foot discomfort can cut down student efficiency not only in the area of gymnastic activities but also in the general lowering of body tone. This should be recognized and handled as a health problem rather than as a problem of behavior. McCloy recommends regular annual health exams as a check on existing problems so that progress or retrogression can be watched.[11]

Turner, Sellery and Smith[12] extended the viewpoint that health is based on "both heredity and environment." Health education is the responsibility of the home, the school and, less directly, the community. The child must be taught to develop health practices even before he is old enough to understand the scientific principles upon which these practices rest.

There is still a great deal to be done to educate students, teachers and the community to the value of good foot health. The work that has been done in the Valley Stream[13], Norwich, N. Y.[14], and the Lubbock, Tex.[15], communities has shown that there is still much to be done in the field of community foot health. These programs have been started as experiments and have been continued year after year, as the benefits of this work of improving the foot health of the children of the community have been shown. Like a stone tossed into a pool, there is a widening effect of improvement in community foot health.

It is to be hoped that such undertakings will be initiated in more and more communities and that foot health education will become an integral part of the program in every school of the nation.

1 DeKalb Ave.

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Clinically Speaking

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

Coral — An Unusual Foreign Body A Case Report

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Mt. Vernon, N. Y.

A 40-YEAR-OLD white female reported to my office with the complaint that she felt as though she was "constantly walking on a stone in her left shoe." Inquiry revealed that the patient had stepped on a piece of coral reef 3 months before while bathing at the beach in Bermuda. She had gone to a medical doctor at the time of the injury. Evidently the doctor removed the piece of coral that was visible, but no X-rays were taken.

Subsequent to the above injury the patient broke her ankle. The foot and lower leg were put into a cast and she was therefore applying no weight to the area for several weeks. However, she again felt pain around the injury upon removal of the cast. This is when she came to me.

My X-rays revealed leaf-shaped foreign bodies lying on the plantar surface under the first metatarsal head, left foot.

Following preparation of the foot for surgery, and using conduction block anesthesia, 4 cc. Carbocaine,®[1] an incision was made on the medial side of the foot. By blunt dissection the foreign bodies were exposed. These foreign bodies were encapsulated in soft tissue, and were removed in toto. A mosquito forceps was used to grasp the pieces of foreign body. Mattress type sutures were used and Telfa®[2] applied over the area with sterile dressings.

Examination of foreign bodies revealed fragments of coral varying from 0.5 cm. to 3 cm. in length. These were pieces apparently left from the original injury.

Patient returned in 10 days to have sutures removed. She felt much better and was discharged the following week.

In summation, the importance of X-ray in any injury of this nature is again demonstrated. If this had been done as a routine procedure, the patient would have been saved 3 months of pain and disability.

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Osteochondritis of the Talus — A Case Report

Charles L. Wahnon, Pod.D.
Martin M. Resnick, Pod.D.
New York, N. Y.

OSTEOCHONDRITIS desiccans is a general term for a group of diseases which affect the osseous system.

According to Pugh,[1] osteochondrosis is best used to describe those lesions that develop spontaneously or without definite evidence of gross trauma. The pathologic change seen in bone affected by osteochondrosis is explained on the basis of aseptic necrosis. There is no indication that infection is present. The cancellous bone is disintegrated and becomes partially absorbed. The bone becomes condensed and fragmented as the result of muscular strain or weightbearing. Replacement by new bone eventually takes place with the laying down of osteoid and the formation of new trabeculae of bone.

In the lower extremities the sites this disease most frequently attacks are: the head of the second metatarsal, head of fifth metatarsal and tibial sesamoid of first metatarsal, patella and tarsal navicular, talus, tibial tubercle, head of femur, epiphysis of calcaneus.

It is said that osteochondritis of the talus is possibly the most prevalent form of the disease second to Freiberg's infraction and is the most disabling in the foot.

DuVries[2] states that the disease occurs during adolescence or in early adult life. The onset is insidious and only infrequently is there a history of direct trauma. The symptoms may point to the talonavicular joint and may simulate a strained longitudinal arch. Pain and tenderness in the ankle joint may or may not be accompanied by swelling. The swelling may be inflammatory or represent effusion into the joint. Pain is aggravated by walking or exercising. Partial immobilization with adhesive gives little or no relief. Pain is the most significant symptom, manifested in two phases, (1) the active phase, when pain is due to an active inflammatory process, (2) the static phase, when pain is due to the instability of the sequestrated ossicle which is loosely attached to the body of the talus.

Case History

A patient, female, 24 years of age, presented herself for examination at our office November 21, 1959, complaining of severe pain in the left ankle on weightbearing. The pain was of an intermittent nature for the previous year with an increase of severity for the past 2 months. Examination of the area revealed a normal range of extension. However, dorsiflexion was limited at 30° with pain at the anterodorsal aspect of the ankle. A noticeable limp was presented. Upon forced manipulation the pain radiated around the lateral malleolus and up the posterolateral aspect of the leg, appearing to follow the course of the peroneal nerve. There was a previous history of twisting of the ankle constantly. The patient's medical history was excellent.

Blood and urine were within normal range. Roentgenograms showed an ossicle on the lateral superior surface of the talus loosely attached. An orthopedic consultation was recommended. Surgery was advised because the condition was in the static phase with symptomatology becoming increasingly severe.

Operative Procedure

Under general anesthesia, a pneumatic tourniquet was placed on the upper left thigh at 500 mm. pressure for maximum hemostasis. An anteromedial incision along the anterior margin of the medial malleolus was made. An osteotomy of the medial malleolus was carried out to expose the entire dorsomedial surface of the body of the talus and permit removal of the diseased bones. The joint mice were curetted out and the malleolus replaced and fastened with a screw. A plaster cast extending from the toes to the knee joint was applied with foot in mild inversion. A walking cast was worn for about 8 weeks.

Postoperative roentgenograms showed no

evidence of the former pathology. The medial malleolus with the screw was well positioned. After 8 weeks the cast was removed and hydrotherapy was administered twice weekly. After 3 weeks of hydrotherapy the patient was discharged.

At this writing the patient has just had her 9-month checkup with no untoward after effects.

2488 Grand Concourse

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Some Comments on Latex Shielding For Hallux Valgus

George A. Kaegi, D.S.C.
Newark, N. J.

In any discussion on methods of treating a specific pathology, there is bound to be controversy. Honest differences of opinion are frequently encountered. In hallux valgus the differences of opinion as to treatment are quite varied. To afford relief and comfort for this condition, it is my opinion that basically we can break down treatment to three types: surgical, temporary palliative and more permanent relief.

Surgery frequently is the method of choice. This is particularly true with the young individual. However, we podiatrists see mostly the chronic type hallux valgus condition. The patient is usually a poor risk for surgery due to inadequate circulation, age, diabetes, or unwillingness to undergo surgery.

We must keep these patients comfortable by removing pressure from the painful joint. This is our second method of treatment, palliative. Occasionally we are able to persuade a patient to wear a special shoe with a pocket accommodation for the deformity, but as nearly all cases of this deformity are in women, social forces require us to devise other means of relief. Thus, we are prone to resort to merely excising a callus and then applying felt pads. This must be repeated monthly or more frequently.

Let me point out the drawbacks of this commonly used pad. First, and most important, is its unsanitariness. These pads collect debris and normal skin desquamation underneath, which in turn cause irritation and sometimes severe dermatitis. Second, they compress to a point where they are no longer effective. Third, they must be adhered by adhesives. In doing this we limit the motion of the very joint we are endeavoring to protect. Fourth, and by no means least of all, is the appearance. They soon become unsightly due to the constant wetting during bathing and from normal or excessive perspiration, and appear anything but professional in appearance within a very short time.

We come to the next more permanent method, shoes of the molded type or custom made shoes. Again we are dealing with the response of the individual to his society, which is our barrier in prescribing correct shoes for such a condition.

Thus, we are forced to look for another permanent, removable device which will remove pressure from the metatarsophalangeal joint. This appliance must fit as accurately as a denture would. It must not limit the motion of the metatarsophalangeal joint. This, of course, can be found in a properly constructed latex appliance. Whether this appliance is made in your own office laboratory, or in an outside laboratory, the most important entity is a good impression and model.

Another factor I would like to bring out is the advantage of shields made on a model over those fabricated on the foot. Perhaps the best example of this is that our modern-day shoe forces the foot to walk or work with the shoe instead of the shoe walking or working with the foot. Thus, when the shield is fabricated on the foot, of necessity it assumes the shape and impression of the shoe.

The latex shield maintains its position on the foot; it maintains the correct density of the protective padding; it is clean; it walks and works with the foot; and last but not least, it is a professional-looking appliance, commanding a professional fee.

Latex shields are not a panacea. They are a permanent method of padding. With a well-fitted latex shield, we can assure comfort for the hallux valgus patient. I do not mean to say, however, that latex shields can be used alone. They must be preceded by proper treatment and then used as a permanent padding to prevent recurrence of the inflammatory processes.

Any prominence or excrescence that responds to podiatry padding will respond to latex shielding.

To fabricate a prosthetic appliance, I must reiterate, it is most important to have an excellent impression. A few rules to follow in obtaining this are:

1. Allot proper time for casting, as haste will certainly result in a poor impression.

2. Take impression of the extremity to receive the prosthetic as soon as patient has removed shoes. It has been my experience that the foot will retain a reasonable shoe position and thus give a better fitting appliance, which of course, is worn within the shoe.

3. Coat part with tincture of green soap. Use this as a separating medium, not vaseline, as this creates plaster bubbles.

4. Mark the extent of the excrescences, spurs, etc., with indelible pencil.

5. In applying plaster splints, always start splints in the web and come over the toe. Never wrap splints around the toe as this distorts the cast. Splints should always run along the axis of the metatarsal and the phalanx.

6. For the extreme contracted, bulbous or ankylosed toe, I recommend the use of the D. P. Dental Impression Compound,® [1] an elastic type of material. Let me caution you that in using this type of material, it is necessary to pour your model very shortly after removal from patient as this compound shrinks. If there will be any delay in pouring the model, wrap the impression in a wet towel and it will not shrink for approximately 4 hours.

The most common cause of failure in latex appliance technique is due to poor impressions and models. Second to this is improper padding, for the latex is merely the vehicle to contain the protective padding.

Latex as a medium for protective pads, clinically has given the least amount of dermatological trouble. Therefore, it is to this date the material of choice.

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Page

This month, Vice President Mullens accepted my invitation to provide the Message for the President's Page.

Marvin D. Marr, D.S.C.

Our Challenge

Recently Secretary Rubin, Dr. Raymond Locke and I attended the annual National Health Forum, sponsored by the 72 member agencies of the National Health Council, on "Better Communication for Better Health."

One of the highlights of the meeting was an address by Arthur Godfrey. Most people were impressed by the depth of his knowledge and concern about medicine's communication problem. He emphasized a great need for all kinds of medical care; the shortage of health personnel, the duplication of effort among professional associations competing with each other, thus creating unnecessary duplication and waste. Mr. Godfrey also predicted that unless measures are instituted immediately to correct the existing problems of communications by those in authority in the health field, and primarily the A.M.A., third parties will step in and call the signals.

The Chairman and most members of the workshop subcommittees were M.D.'s. Medicine, as usual, had a large hand in setting the climate and policies for the meeting.

It was obvious from the meeting that medicine is acutely aware of the deterioration of its image and is seeking ways to improve it. From the summary report: "A disease that looms as a major threat has been isolated. It is called 'communications breakdown.' It may occur on at least three levels—between researchers and health practitioners, among health practitioners themselves and between practitioners and the public.

Although the existence of 'communications breakdown' has long been recognized by scientists, health practitioners and communications specialists, its increasing prevalence has stimulated new effort to analyze the problem in order to move toward solutions. Adding to the communications barrier among professionals are interprofessional jealousies, insecurities, fears, anxieties and urges for status that beset many professional persons."

From other sources we know, we learn that additional plans by the A.M.A. to combat "communications breakdown" are: 1) An increase of dues, part of which is earmarked for "the expansion of the Communications Division of its program of faithfully portraying the image of the A.M.A." 2) Expanded public relations programs at the State and County levels. 3) Recommendations that State Medical societies take the initiative to set up state associations of the professions. The professions invited by medicine to participate are engineers, veterinary, law, architects, dentistry and pharmacy. 4) In Detroit a meeting was held February 22-24 to promote the new American Association of Professions. "To say this is not a pressure group is wrong," says Hugh A. Brenneman, Executive Secretary of the American Association of Professions. "As does any worthwhile organization, A.A.P. will have very definite opinions affecting professions generally—and will make these opinions known and felt."

To date, A.P.A., while a participating organization, has not been admitted to membership in the National Health Council and has not been invited to join the Associations of Professions.

Since there exists an admitted "communications breakdown" among the major health professions and agencies, the greater seriousness of podiatry's position in areas of communications becomes obvious, as the public knows little or nothing about us. And even worse, many who have been exposed to podiatry in the past have a poor image of our profession. During the past few years, in our quest for "recognition" we have encountered this situation at all levels and it is always a shocking, but revealing experience when we come face to face with this ugly fact. This year we again encountered the same problem when new agencies were contacted in the ever-expanding program of our National Organization. Considering our limited personnel and resources, we have done reasonably well with spasmodic, sporadic and piecemeal attempts at Public Education and Information. However, this approach leaves much to be desired.

It is the considered opinion of many thoughtful members of our profession that only when the "publics" will have been educated to instructively consider the podiatrist as the natural person to call upon for their foot problems, will podiatry win just recognition as a healing art to rank alongside of medicine and dentistry. Only when the "publics" will have begun to accept, as a matter of course, the family podiatrist, as they do the family physician, will resistance to podiatry begin to disintegrate.

A professional in the field of communication who is familiar with our problems recently made the following observations:

> "The foundation for virtually any complete program of public information and education is 'Research.' It is patently unrealistic to reshape or redirect the opinions and attitudes of the public unless we know for certain what the attitudes and opinions of the public are today. Your profession must be concerned with at least three distinct publics, i.e. the general public, the educational community and the other allied professions.
>
> "What do the members of these three publics think of you? What are their attitudes with respect to your profession? What are their opinions of you as professional people? These are just a few of the crucial questions to which answers must be found before a fully realized resultful public education and

information program can become a reality. Every member of the profession will readily agree, I think, that podiatry has its problems. But I question whether it would be possible to find anything approaching unanimity among you as to what these problems are.

"Of this I am certain—you will all agree that your primary objective is to broaden the scope of your service to the community. I think you'll agree, too, that the ultimate success of any profession is determined by the degree of its service to the community. But we must recognize that far more subtle forces are involved than the common misconceptions and stereotypes we are so accustomed to hearing about podiatry.

"To me it's unthinkable that 7,000 podiatrists should be enough to serve the need of this country. The overwhelming need should require many more of you in practice.

"But I submit that the greater part of your three publics is not yet aware of its needs for podiatry. The big effort should be directed at finding out the qualitative 'what' and 'why' of public opinion for accurate diagnosis before you can move ahead with a full-scale campaign designed to change or redirect it.

"The real beginning of the podiatry story is at hand. As the great Cervantes wrote in 'Don Quixote': 'Make it thy business to know thyself, which is the most difficult lesson in the world.' "

We cannot afford to wallow in frustration any longer. In spite of all our past efforts, we are on a treadmill to nowhere. If podiatry is to survive, we must face up to the ugly facts with courage, vision and determination.

We must call in competent professional consultants to study podiatry's "image" on the health scene and recommend to us: (a) what additional personnel we need, (b) what actions we must taken to improve the "image" of podiatry which has so much to offer in the public interest, and (c) what practical and legal steps, if any, they recommend to attain full recognition in all areas in which our education and "know how" merits.

After receiving a professional evaluation and recommendations, every member must have the vision, the will and dedication to support such a program. We owe this to ourselves and to the public.

BENJAMIN C. MULLENS, *Pod. D.*

Notice to Contributors to Educational Fund

The lists of contributors to the Educational Foundations of the various colleges and the Fund for the Advancement of Podiatry-Chiropody Education which appeared in the February 1961 Journal, listed only those who had contributed during 1960. Contributors during 1959 were included in the FUND article appearing in the January 1960 Journal.

OFFICIAL NOTICE
ANNUAL MEETING — HOUSE OF DELEGATES
AMERICAN PODIATRY ASSOCIATION
AND
ANNUAL SCIENTIFIC SESSIONS
AMERICAN PODIATRY ASSOCIATION
NATIONAL ASSOCIATION OF CHIROPODISTS

To Component State Societies and Affiliate Organizations

Announcement

In compliance with Article VI of the Constitution and Chapter IV, Section 5 of the Bylaws, you are hereby notified that the Annual Meeting of the House of Delegates of the American Podiatry Association will be held at the time and place indicated on this announcement for the purpose of receiving reports of officers and committees, for the annual election of officers, for action upon regularly offered amendments to the Constitution and Bylaws and for such other business which may be presented.

Time and Place

Forty-second Annual Session of the House of Delegates, Americana Hotel, Bal Harbour, Miami Beach, Florida, August 24, 25 and 27. The first session will begin 9:00 a.m. on Thursday, August 24.

Representation

Chapter II, Section 5 of the Constitution provides that component state societies be represented in the House of Delegates in the ratio of one delegate for each one hundred members or fraction thereof as of the close of the fiscal year ending May 31, 1961.

Certification of Delegates

The secretary of each component state society shall file with, and on a form furnished by, the Secretary of this Association at least thirty (30) days prior to the annual sessions of the House of Delegates the name of each delegate and alternate selected by his society. The Secretary of this Association shall provide each delegate and alternate with a credentials certificate to be presented to the Committee on Credentials for registration and admission to the meetings of the House. In the event of a contest over the credentials of any delegate or alternate, the Committee on Credentials shall hold a hearing and report its findings and recommendations to the House for final action. Credential certificates must be presented in person to the Committee on Credentials at the time and place of the meeting set forth in this announcement. No delegate or alternate will be seated until his credentials have been approved by the Committee. Each delegate or alternate must present evidence of registration for this annual meeting and of being in good standing.

Resolutions

Proposed resolutions intended for submission to the House of Delegates should be in the hands of the Secretary on or before July 15.

Annual Scientific Sessions

As provided in Chapter XI, the Forty-ninth Annual Scientific Sessions of the American Podiatry Association, National Association of Chiropodists will be held at the Americana Hotel, Bal Harbour, Miami Beach, Florida, August 26 through 29, for the presentation and discussion of subjects pertaining to the science and art of Podiatry-Chiropody.

Authorization

In accordance with the above article, chapters and sections, the Board of Trustees has authorized that the scheduled meetings be convened at the time and place indicated above.

Registration

Each person, whether or not a member, sixteen years of age or over, attending the convention shall be registered and admission to meetings, clinics, lectures and all other convention activities will be refused to those not so registered. All members shall pay the registration fee set by the Board of Trustees. Non-member podiatrists-chiropodists will not be permitted to register.

Invitation to Members

A cordial invitation is extended to all members. Each component state society and affiliate organization is urged to send as large a delegation as possible in addition to the accredited representatives of the House of Delegates.

MARVIN D. MARR, D.S.C., *President*

Dated: May 1, 1961

Attest:

A. Rubin, D.S.C., *Secretary*

PROPOSED AMENDMENTS TO THE BYLAWS of the AMERICAN PODIATRY ASSOCIATION

Propositions A through F, inclusive, are submitted by the Board of Trustees. The recommended change from thirty (30) to forty-five (45) days in Proposition A is to allow for more time to arrange details in regard to credentials and naming of certain House Committees directed by the Constitution. Propositions B, C, D, E and F are language changes in the Constitution in order to enable the House of Delegates to approve an annual budget two years in advance. Presently, the House meets at the end of the first quarter of the fiscal year in which it approves the budget, which means that one quarter of a year has passed before the House of Delegates has an opportunity to consider the budget for that fiscal year. Propositions B through F will make it possible to submit two budgets to the 1961 House of Delegates, one for the fiscal year June 1, 1961 to May 31, 1962 and a second budget for June 1, 1962 to May 31, 1963. At the 1962 annual meeting the House would review the budget adopted the previous year and would adopt a budget for 1963-64.

Proposition A

Chapter IV, House of Delegates, Section 2, Certification of Delegates, Page 6, Lines 55 and 56.

Change *"thirty (30)"* to **"forty-five (45)"**

Proposition B

Chapter IV, Section 3, Powers and Duties, Page 7, Line 11.

Delete present *subsection H* and substitute therefor:

H. It shall adopt a budget for such period or periods of time as it deems appropriate; the budget shall be subject to annual review and revision.

Proposition C

Chapter IV, Section 12, Standing Rules, Page 8, Lines 45 through 48.

Delete present *subsection C* and substitute therefor:

C. Consideration of the Budget. The budget presented for adoption, review or revision shall be presented to the House prior to the last scheduled meeting of the annual session of the House.

Proposition D

Chapter IV, Section 13, Committees, B. Budget Committee, Page 8, Lines 70 through 73. Delete *paragraph b* and substitute therefor:

b. Duties: The Budget Committee shall consider and review the proposed budget, all subsequent revisions of the budget and all other proposed appropriations and expenditures.

Proposition E

Chapter V, Board of Trustees, Section 7, Duties, Page 10, Line 3.

Subsection 5. Delete *"an annual budget"* and substitute **"the budget."** Add a new sentence to this section:

It shall make recommendations to facilitate the annual review of the budget and other fiscal matters by the House.

Proposition F

Chapter VIII, Standing and Special Committees, Section 9, Budget and Reports, Page 14, Line 30.

Place a period after the word "House" and strike *"for the ensuing fiscal year."*

The Constitution Committee agrees unanimously to approve the suggested revisions (Propositions A through F, inclusive) involving Chapters IV, V and VIII, as submitted.

L. C. Numbers, D.S.C., Chairman; J. E. Adams, D.S.C.; J. D. Fletcher, D.S.C.

News of the Profession in Great Britain

Franklin Charlesworth, Ed.D., D.S.C., F.Ch.S.
Manchester, England

A regular series of "letters" about the profession in Great Britain, by Mr. Charlesworth, Editor of the British Chiropody Journal, or arranged for by him, will appear in this column.

British-American relations are always a subject of considerable discussion because it becomes increasingly obvious that it is vitally important that these two great countries should come to a full and mature understanding of each other.

It is amazing how illogical we are on this subject of good relations. One stuffy and snobbish Englishman can bring a spate of uncomplimentary observations from our American friends. One over-boisterous and flamboyant American can bring corresponding hostility from this side of the water.

It is frequently said that one swallow does not make a summer and, by the same rule, an English stuffed shirt does not make Great Britain, nor a loud and flamboyant American the United States of America, and even the two types referred to may not be such bad types when you get to know them. The bloke from Britain may be just a guy who is over-anxious not to put a foot wrong and therefore appears much more stuffy than he normally is, whilst the American "doing Europe" may be having a whale of a time and has just gotten himself a bit out of perspective and under normal conditions may be quite a modest and decorous individual.

A great deal depends upon how you approach the other fellow. If you start off by being aglow with friendliness and unreservedly offer the hand of friendship, nothing can go wrong.

Britain and America have too much basically in common, true freedom and democracy where every man is free. The British Empire was something these little islands of Britain have every reason to be proud of. Its conversion to a commonwealth of nations in which past colonies and dominions have shown an eagerness to be partners is a glowing compliment and I feel that we have not been ungenerous in our contributions for the fight for space and the preservation of liberty and justice.

The history and development of the American nation is one of the most inspiring episodes in human history and America's generous contribution in the fight for freedom and democracy, not to speak of their great generosity in the re-establishment of war-ravaged Europe, should bring the grateful and heartfelt appreciation of all Europe.

Our two nations have achieved so much and are left to carry such a grave responsibility that to bicker over trivialities would not do justice to our present status in the world.

It is to the credit of American chiropody that the initiative was taken in relation to our profession. As the recipient of your great generosity and friendship, I was not only impressed with these qualities but with your sincere and earnest desire to initiate efforts for mutual understanding and good will between chiropodists the world over, particularly between Great Britain and America, and your desire to make positive contributions to the achievement of the highest academic standards and status for our profession, not only in your own country, but everywhere.

The rank and file of the profession in Great Britain have shown great eagerness to have knowledge of their American colleagues, their status, methods and scope of practice, the layout and conditions of private practice in America.

The visit of Dr. Shapiro to our shores was a tremendous success. His approach could not have been more psychologically perfect. His honesty and sincerity impressed everyone with whom he came in contact and in

his visit he performed a service not only to our profession but toward good fellowship between nations which cannot be overestimated.

We have had other visitors from America coming under less important and less formal conditions. It is only by ever-increasing contact between us that we will learn to know each other. Britons will not necessarily like every American they meet any more than Americans will take to every Briton, but beneath the surface of differences in temperament and background, we will find if we are patient and tolerant with each other, a fundamental core of sound and stable character based upon our repeated fights for liberty, justice and true democracy.

As members of a profession which has direct and personal contact with millions of their fellow human beings who often pour out to us their personal human problems and in whose judgment they place great confidence, British and American chiropodists can do much to spread the gospel, not only to friendship and good will, but mutual confidence and loyalty between our nations, thus forming an invincible barrier to the onslaught of Communism. In brotherly love, peace and truth, Britain and America, side by side, will provide a rallying point and inspiration to the whole free world.

British and American chiropody, in combination, can make a vital contribution to this ideal.

Podiatry-Chiropody Abstracts

Jerome Shapiro, Pod.D.
5429 Connecticut Ave., N.W.
Washington, D. C.

Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

Treatment of Pruritus and Xerosis of Various Dermatoses—Evaluation of a Bath Oil.

Irwin I. Lubode, M.D., F.A.C.A., Western Medicine, 1:45 Dec. 1960.

The dry pruritic skin has always been a problem in many dermatoses and the most practical treatment has been to apply an oily medicament to reduce the rate at which water is lost by the stratum corneum to the environment. Preliminary studies with a specific water-miscible oil, "Sardo" reported good results in treating various dry dermatoses when the preparation was used in the bath.

Fifty patients with dry, pruritic, scaly skin were selected at random from a dermatology practice. Diagnosis included anogenital pruritus, dermatitis venenata, neurodermatitis, lichenified dermatitis, and miscellaneous conditions. The water-miscible bath oil Sardo, five drops to a quart of warm water, was applied in a compress form 3 to 5 times a day. In 94% of the group (47) the oil-water compresses reduced inflammation, itching, irritation and other discomforts of the primary dermatoses. The 94% improvement is substantially higher than was obtained under similar conditions using water compresses without the oil additive. There were no irritations or discomfort from the oil preparation.

Plantar Warts Are Often Mistaken For Calluses

Morton H. Walker, D.S.C., Boot and Shoe Recorder, Aug. 15, 1960.

This is well-written and well-organized lay discussion on plantar warts. The author explains the many ways one differentiates between a plantar wart and a callus. The cause is probably a virus with trauma playing a secondary role as a causative factor. However, mention is made of some metabolic or endocrine disturbance as a

possible cause. Although warts in themselves are not dangerous, self treatment might produce complications. There are a dozen or so treatments for a wart which means that there is not one good one. Seven methods of wart eradication are outlined, including chemical acids, hyfrecation, surgical excision and psychotherapy. It is suggested to the shoe salesman to discourage customers from using home remedies on warts but rather to seek professional advice.

Modern Concepts of Morton's Neuralgia

Roelof Tikker, D.S.C., Current Podiatry, Vol. 10, No. 1, Jan. 1961.

In over 200 cases of surgically treated neuromas, the following symptoms very often accompanied the classic one of severe cramping in the forefoot at the involved met heads necessitating shoe removal: 1) Burning and stinging on the ball especially if there is a painful callus overlying the second, third and fourth metatarsal heads. 2) Shooting pain starting at the lateral area of the foot and going up the entire leg into the low back area following the course of the sciatic nerve. 3) Numbness and tingling which may involve the entire foot. The surgical treatment is briefly mentioned with the author favoring the dorsal approach as opposed to the plantar approach due to the amount of adipose tissue one has to contend with plantarly. During the postoperative management of the patient the author utilizes ultrasonics to relieve congestion and/or swelling that might persist.

Psychosomatic Disturbances

Alan A. Robbins, Pod.D., Current Chiropody, Vol. 9, No. 10, Oct. 1960

It is of the utmost importance for the podiatrist to be able to distinguish between a patient's debility actually caused by a physical phenomenon as opposed to one caused by some form of psychological disturbance. In the taking of a careful history one must remember that any patient with a psychosomatic syndrome actually feels the pain and symptoms he or she describes. Herein are reported two cases of psychosomatic disturbances with symptoms in the foot. Both cases presented symptoms that had been present for many months and standard therapy had failed in each instance. Both patients responded dramatically to tranquilizing drugs.

Use of Vitamin A in Treatment of Multiple Mosaic Papillomata

Paul C. M. Ladelpha, D.S.C., Canadian Podiatry Journal, Vol. 16, No. 4, Oct. 1960.

The patient presented herself with a large number of mosaic papillomata on the plantar surfaces of both feet which had coalesced into several large plaques. Attempts at surgery and electrodesiccation had failed, including other forms of more conservative treatments. Vitamin A solution was injected into both plaques at weekly intervals using 0.3 cc. in each foot. After six injections Vitamin A oral was instituted along with the injections. After a total of 6 cc. of Vitamin A solution over a period of 3 months, and Vitamin A oral 5 million units over a period of 5 months, all lesions had resolved. It is noted that only the largest lesions were injected but all lesions disappeared.

"The less a man thinks or knows about his virtues the better we like him."

—*Ralph Waldo Emerson*

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Vasodilan

Composition: Vasodilan is isoxsuprine hydrochloride, Mead Johnson, a new synthetic compound.

Mode of Action: The myo-vascular relaxant action of Vasodilan is manifested by selective relaxation of smooth muscle in the peripheral and cerebral vascular beds and in the uterus.

Indications: For peripheral vascular disease. Indicated for the symptomatic relief of intermittent claudication, coldness or numbness of extremities, leg pain and trophic ulcers associated with arteriosclerosis obliterans, diabetic vascular disease, Buerger's disease, thrombophlebitis, Raynaud's disease, acroparasthesia and frostbite. Cerebrovascular disorders, cerebral impairment wholly or partially due to deficient circulation resulting from arteriosclerosis or hypertension.

Advantages: Vasodilan produces its beneficial effects by direct action without adverse effects on the nervous system. It is rapidly absorbed and produces its maximum effect within 1 hour. Its therapeutic effect lasts 3 hours or more. Well adapted for long-term administration, Vasodilan is well tolerated, has no cumulative effect and is remarkably safe in recommended doses. Vasodilan is notably free from adverse effects and its action is not accompanied by gastric hyperacidity, ganglionic blocking action or toxic reactions on blood, liver or kidney. This preparation may be used safely in patients with coronary disease, diabetes, peptic ulcer, asthma or other bronchoconstrictive disorders.

Side Effects: Few side effects occur in recommended oral doses. Occasional palpitation and dizziness can usually be controlled by dosage adjustment. Single doses of over 10 mg. at one time are not recommended as they may result in hypotension or tachycardia.

Contraindications and Cautions: There are no known contraindications to oral administration in recommended doses. Intramuscular administration is not recommended in the presence of hypotension or tachycardia. Intravenous administration is *not* recommended.

Dosage and Administration: Orally 10 to 20 mg. (1 or 2 tablets) 3 or 4 times daily. Intramuscularly 5 to 10 mg. (1 to 2 cc.) 2 or 3 times daily. Intramuscular administration is indicated for the treatment of patients with acute and severe symptoms due to arterial insufficiency associated with peripheral and cerebrovascular disease. As the acute and severe symptoms are controlled, the patient should be maintained on oral therapy.

Supply: In 10 mg. tablets in bottles of 100 and in ampules of 2 cc. (5 mg. per cc.) in boxes of 6. By Mead Johnson and Co., Evansville 21, Indiana.

Neopan Cream

Description: Anti-infective, antibiotic-vitamin combination, dermatologic. Each gm. of cream contains neomycin sulfate, 5 mg. (0.5%), equivalent to 3.5 mg. neomycin base; pantothenylol, 20 mg. (2%); water-miscible cream base.

Action and uses: Provides topical antimicrobial treatment and prevention of skin infections. It combines the wide-spectrum antibiotic neomycin with the antipruritic, healing efficacy of pantothenylol. Well tolerated, nontoxic and virtually free from

sensitivity reactions. Indicated for use in pyogenic dermatoses, infected wounds, burns; varicose and trophic ulcers; impetigo; folliculitis; furunculosis; etc. Also in herpes simplex and localized neurodermatitis.

Administration: Topically. A sufficient amount applied to cover affected areas, once or twice daily.

Supply: In jars of 2 oz. and 1 lb. By U. S. Vitamin and Pharmaceutical Corp., 250 E. 43rd St., New York 17, N. Y.

Medaprin

Description: Analgesic, anti-inflammatory tablet. Each tablet contains Medrol (methylprednisolone) 1 mg., acetysalicylic acid 300 mg. and calcium carbonate 200 mg.

Indications: Mild to moderately severe rheumatic and musculoskeletal conditions not adequately controlled by salicylates alone. Medaprin is also useful for maintenance therapy in mild to moderately severe rheumatoid arthritis.

Dosage: 1 or 2 tablets 3 or 4 times daily after meals and at bedtime.

Precautions: Medaprin should be used with caution in the presence of infection, diabetes, osteoporosis, psychotic reactions, tendency to thrombophlebitis, hypertension and congestive heart failure.

Contraindications: Tuberculosis, renal insufficiency, peptic ulcer, acute psychosis, Cushing's syndrome and herpes simplex keratitis.

Supply: As press-coated tablets in bottles of 100 and 500. By The Upjohn Company, P. O. Box 831, Kalamazoo 99, Mich.

Tigan

Generic Name: Trimethobenzamide hydrochloride.

Description: Antinauseant, antiemetic. Each blue and white capsule contains 100 mg. of Tigan, brand of trimethobenzamide Hcl. and each blue capsule contains 250 mg. of Tigan, and for intramuscular use, there are available multiple dose vials of 30 ml. Each ml. contains 100 mg. of Tigan.

Action and Uses: This drug is indicated for the use and treatment and in the prevention and control of nausea and vomiting. It is reported to have a selective and specific action on the chemoreceptor trigger zone in the medulla, the area through which impulses travel to the vomiting center. Because of the selective action of this drug, it is reported not to produce sedation, excitation, hypotension or other significant side effects. It is used in the prevention and treatment of nausea and vomiting which may occur in pregnancy, postsurgery, Meniere's syndrome, motion sickness, postradiation therapy and in association with various drugs.

Administration: Orally or intramuscularly. Orally, the recommended dosage is 1 or 2 capsules every 4 hours or as necessary.

Supply: Capsules in 100 mg. each (blue and white) in bottles of 100 and 500. Also in blue capsules of 250 mg. each in bottles of 50 and 100. Ampules for intramuscular administration in 2 cc. (100 mg./cc.) boxes of 6 and 25. Also in suppositories of 200 mg. in boxes of 6. By Roche Laboratories, Division of Hoffman-LaRoche, Inc., Nutley 10, N. J.

Carbo-Dome®

Description: Creme or lotion (pH 4.6) containing liquor carbonis detergens 5%, 10% or 15% in Acid Mantle® vehicle, to permit the doctor to suit the "tar" treatment to the disease or condition. It is a stainless, water washable, cosmetically elegant coal tar topical. The Acid Mantle® vehicle potentiates the action of the liquor carbonis detergens content of Carbo-Dome, restores and maintains the normal protective acidity of the skin and facilitates healing.

Indications: Atopic dermatitis, infantile eczema, nummular eczema, seborrheic dermatitis, psoriasis, neurodermatitis, dishidrosis and other chronic recalcitrant dermatoses.

Directions: Apply morning and night to affected areas.

Supply: In 5% strength, 1 and 4 oz. tubes as creme or 2 and 4 oz. bottles as lotion. By Dome Chemicals, Inc., 125 West End Ave., New York 23, N. Y.

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

Anesthesia and Analgesia

Influence of Absorption on Systemic Toxicity of Local Anesthetic Agents, Adriani, J., Campbell, D., and Yarberry, O. H., Jr., Anesth. & Analg. 38: 370-377, Sept.-Oct. 1959.

If a local anesthetic agent is absorbed slowly during injection, few if any systemic effects follow—such effects are due to high plasma levels. The injected agent passes through the vascular system and is eliminated or detoxified. Reactions are more frequent after topical application than after injection. When blood levels in this study were compared following injection and topical application of tetracaine, procaine, and benzocaine, absorption proved most rapid after application to the mucous membranes, unless the intravenous injection was rapidly done.

Experiments in dogs showed rapid injection of tetracaine produced respiratory paralysis, but slow infusion of equal dosage caused no reaction. However, a prolonged slow infusion has cumulative results and eventually produces systemic toxicity. When the total amount of tetracaine or cocaine was divided into three portions and applied to the pyriform fossae at 3-minute intervals, peak levels were reached 10 minutes after application of the final fraction. Although the peak levels are lower and are reached more slowly when the dose is divided, the peak levels are much higher than those following infiltration or slow effusion.

Absorption of local anesthetic agents, after subcutaneous and perineural infiltration, is retarded by the vasoconstrictors. By addition of 1:100,000 epinephrine to the procaine injected subcutaneously, systemic toxicity is decreased up to 30 per cent. When epinephrine is added to the drug, spinal anesthesia will be prolonged from 40 to 60 per cent. Norepinephrine is nearly as effective as epinephrine, but causes sloughing and necrosis of tissues. Phenylephrine is less effective and larger doses are required to produce vasoconstriction. Ephedrine is ineffective. Cocaine promotes considerable vasoconstrictor activity.

Local anesthetic agents pass into the blood only if the skin is abraded. Application of a 'caine drug to a burnt area covered with vesicles produces no detectable blood levels, but when applied after opening the vesicles or after removal of the eschar, it produces a measurable increased blood level. Local anesthetic agents, therefore, should be applied to raw, granulating or burned surfaces. A cocaine base incorporated in water soluble ointments and applied to mucous membranes is easily and freely absorbed. The period of latency varies in local anesthetic drugs. It can be shortened by using more concentrated solutions. Anesthesia will be inadequate if surgery immediately follows application of the drug. The latent period, except for benzocaine, is 5 minutes or more; tetracaine is longest lasting and most potent of the topical anesthetics. Procaine is used as the standard of comparison of toxicity and potency of these agents. Procaine used for perineural injection or infiltration is limited to 1 gm. at any one time; 50 cc. of a 2 per cent solution or 200 cc. of .5 per cent solution is the maximal dose injected. Tetracaine is ten times more potent and toxic; dosage is 100 mg. Piperocaine (Metycaine) is slightly more potent and toxic than procaine (1 gm. maximal limit). Lidocaine (Xylocaine) is twice as potent and toxic as procaine (.5 gm. limit). The dosage of hexylcaine (Cyclaine) and chlorprocaine

(Nesacaine) like cocaine should not exceed 1 gm.

Topical use, because of more rapid absorption, in small quantities may cause reactions in some patients due to intolerance, or to difference in the technic of application. Also, in some cases a difference arises because the total amount was not absorbed.

Used as a spray, overdosage can occur. A proper spray delivers particles of a size which coats the pharynx and trachea in a thin film without coalescing into a pool or forming a mist which is inhaled into the alveoli. Most sprays used are unreliable; one squeeze may deliver 1 cc. of fluid each time and lead to overdosage. The Carabelli spray delivers a mist which lodges in the nose, pharynx and trachea; approximately 25 squeezes of the bulb are required to deliver 1 cc. of fluid.

Allergic reactions due to repeated anestization cause cutaneous lesions, but they are rare if the patient is exposed once or twice. On rare occasions an individual may have an anaphylactoid reaction and sudden circulatory collapse, possibly due to histamine release. Skin tests are less helpful than nasal tests. Intolerance is shown by bradycardia, hypotension, tremors, or nausea. It must be remembered that in the true allergic patient, the test dose administered intradermally or placed in the mucous membrane, even in minute quantity, may precipitate a severe, even fatal, anaphylactic reaction.

Speed of Action of Aspirin, Soluble Aspirin, and Buffered Aspirin, Sleight, P. Lancet 1: 305-07, 1960.

Six healthy volunteers who had not taken a salicylate within 72 hours were given 10 gr. doses of aspirin in four forms, using the double blind technic in the test. Aspirin B.P., calcium aspirin B.P., Paynocil,® and Bufferin® were each taken two hours after breakfast (on different days). The tablets were crushed in water because they disintegrate differently. Blood levels were determined for each drug 10, 20, and 30 minutes afterward. Soluble aspirin B.P. produced approximately twice the blood level changes of the other three drugs, which were much the same. Plasma levels for acetylsalicylic acid differed little for the four drugs given. Plain aspirin is approximately half as rapidly effective as soluble aspirin. Paynocil and Bufferin which contain plain, not soluble aspirin, are also less rapid in action. It appears that the two proprietary preparations are less irritating than aspirin which delays gastric emptying, and emptying is more rapid than in the case of aspirin B.P.

The experiment demonstrated that under standard conditions calcium aspirin B.P. is as effective in altering blood levels rapidly as the two proprietary buffered aspirins, but that all three are superior to plain aspirin B.P. The superiority of aspirin over plain aspirin in the rapid achievement of demonstrable blood levels is stressed. The evidence incriminating plain aspirin as a cause of serious side effects, such as gastrointestinal hemorrhage, makes its continued use questionable.

Arthritis and Rheumatic Diseases

Juvenile Rheumatoid Arthritis, Norcross, B. M. Minnesota Med. 42: 1760-67, 1959.

Over a 21-year period 80 patients who had juvenile rheumatoid arthritis were observed, or 2.7 per cent of all ambulatory and hospitalized rheumatoid arthritic patients treated. Sixty-two children up to 12 years of age were studied periodically for more than 7 years. Less than 10 per cent had a familial history of rheumatic fever or rheumatoid arthritis. In 25 per cent of these children the disease was mild and had a duration of less than 2 years. Onset of the disease usually occurs during or before the third year, followed by a secondary rise in the eighth to eleventh years. In the present series onset in 56 per cent was in the third year, in 30 per cent between the eighth and eleventh year, and in one child in the tenth month.

Respiratory infections may be considered as precipitating, not causative, factors. Such

infections were noted just prior to onset in 45 to 57 of reported cases. In this series 35 per cent had a history of previous infection (with hemolytic streptococci recovered from the throat). Trauma to a joint appears coincidental in children, not causal. Onset was insidious in 74 per cent, with painless swelling of one or more joints. Mild fever, anorexia, weight loss and anemia occurred in 10 children. Onset was acute and symptoms severe in 26 per cent. These patients had a protracted illness with frequent recurrences and usually a poor final outcome.

Systemic manifestations were present in 40 per cent. Early weight loss and stunted growth usually became normal as active disease subsided. Four had permanent defects due to premature epiphyseal fusion; 12 had friction rubs and electrocardiographic abnormalities; 2 developed cardiac failure during an acute attack. Six of the 12 later showed no cardiac involvement; 3 others developed valvular disease. Three died of complications.

The large joints, especially the knees, were involved in the younger patients (36 initially and later 22 additional). The ankle was involved in 4 initially and 26 more after puberty. The foot was affected in 4 at first and later in 10 additional. In only 6 patients (9 per cent) was only one joint affected during the course of the disease. The average duration of activity was 5½ years, but recurrences were noted for periods up to 20 years; 66 per cent had only one recurrence; 33 per cent had many. Recurrence followed upper respiratory infection in only 7 patients and severe trauma in 3—in 2 of these 3 the disease had been inactive for 10 to 12 years. One woman had no recurrence until she became pregnant 16 years later.

Treatment, as for the adult, consists of complete bed rest until joint inflammation has subsided, physiotherapy, supportive therapy and orthopedic therapy to prevent or correct deformities. Sixty-five per cent improved following gold treatments. Hormone therapy brought clinical improvement, but progressive arthritic changes were shown roentgenologically in some. Mild cases responded to conservative therapy and chrystotherapy. Prognosis was good for functional recovery in 77 per cent, but poor in cases of prolonged activity or acute onset with severe constitutional reactions.

Dermatology

Dermatomycoses Treated with Griseofulvin, Goldfarb, N. J., Rosenthal, S. A., et al. Antibiotic Annual 7: 693-700, 1959-60.

Mycologic lesions in 137 patients were treated orally with griseofulvin, usually on a maintenance dose of 1 Gm. daily, but in some cases doses ranged from 0.25 to 3 Gm. per day. Mycologic, liver, and kidney function tests, and blood and urine examinations were made during the treatment periods. Observations were made for a period of several weeks to 10 months. *T. rubrum* infections of the toenails in 57 patients showed slower response than those in other sites. In 45 (79 per cent) of these 57 cases, new nail formation occurred in 1 to 3 months under a daily dosage of 0.75 to 1.0 Gm. of griseofulvin. In a group of 12 patients observed during 4½ to 6 months' treatment, formation of new nails ranging from 30 to 70 per cent of the normal nail length was observed. Cure was obtained in only 2 patients (3.5 per cent) after therapy of 3½ to 5 months. In several instances after slight improvement no further progress was made despite continued therapy for several months.

In contrast, in 39 patients with onychomycosis of the finger nails due to *T. rubrum*, new normal nails began to emerge in 36 (92 per cent) in the first to tenth week of treatment with griseofulvin (1.0 Gm. daily); 16 (41 per cent) achieved cure within 2 to 6 months of treatment, and 22 showed varying degrees of improvement. One patient dropped out although improving.

Of 65 patients with tinea pedis treated with 1 Gm. daily, 39 (58 per cent) showed clinical improvement at the end of 2 weeks, and the remaining patients in 3 weeks to

2 months. Itching was greatly decreased in 2 to 4 days. The hard keratin masses on the soles gradually diminished following 2 to 3 months of griseofulvin therapy.

Few undesirable reaction occurred, and were of minor consequence, in the entire group. Only occasionally was therapy discontinued because of severe headache, persistent diarrhea, or extreme fatigue. Of the patients clinically cured with griseofulvin, one third continued to be mycologically positive. These patients were considered to be in the "healthy carrier state."

Efficacy of a Bath Oil in the Management of Dry Skin, Weissberg, G., Clin. Med., June 1960, pp. 1161-66.

Extreme dryness of the atmosphere for a prolonged time, excessive and repeated exposure to the sun or other causes of loss of moisture from the skin causes the skin to become dry and scaly. If the skin lipids, which help to keep the water loss at a minimum, are also lost, the skin loses its capacity to retain water and it peels off. Normally the skin lipids form a water-in-oil emulsion in the top layers of the epidermis. Dry skin may itch, fissure, and become subject to superficial infections. Middle-aged persons who acquire a deep tan to look younger actually age the skin by excessive exposure to the sun. They then use emollient ointments, creams and lotions to moisten the dry skin. A better measure is to lubricate the entire skin by use of an oil bath which leaves a film clinging to the skin, giving it the protection afforded by natural skin lipids.

A group of 118 patients with very dry skins, with or without associated skin diseases, were treated from 4 to 16 weeks and observed weekly or biweekly. They took daily baths, with 8 cc. of a bath oil* added to the water. All responded favorably within 2 weeks; scaling disappeared and the skin became softer and smoother. In cases where other treatments were being received for associated skin conditions, the oil bath was prolonged for some time to be certain that some improvement could be credited to the oil therapy. Patients with chronic, irreversible skin conditions were benefited although the primary disease was unaltered. Patients with acute inflammatory dermatoses, anogenital neurodermatitis or nummular dermatitis responded rapidly. Addition of oil to hydrotherapeutic baths prevented dryness and itching of the skin. Only 4 of 11 patients with psoriasis responded and only 11 of 20 patients with atopic dermatitis were benefited. In all, 59 of the 78 patients with skin disorders, or over 75 per cent, were benefited. Of the total 118 patients with dry skin, over 90 per cent had excellent or good results. The oil bath is not a cure for dry skin, although very beneficial; when discontinued, the dryness recurs. No reactions of primary irritation or allergic sensitivity followed its use.

*Sardo®, Sardeau, Inc.

New Growths

Suggestion and Warts: A Review and Comment, Ullman, M. Psychosomat. Med. 21: 473-88, 1959.

Spontaneous remission of warts, as reported in 1893, is still an inexplicable phenomenon, and the duration of cure unpredictable. Most investigators feel that this spontaneous cure is associated with suggestion—in fact, even in successful x-ray, drug, and surgical treatment, suggestion is an underlying factor in the cure. An affective response is set up first in the patient (by embarrassing him, by blindfolding him to mystify and create expectancy, or by simulating medical technics). Lay methods, varying from queer to disgusting, seem the most impressive and efficacious; yet, skepticism and disbelief on the part of the patient do not prohibit success. The response rate is higher with juvenile warts than with the vulgar type, and in cases of multiple rather than single warts. That emotional factors are concerned in production of warts or susceptibility to inoculation has not been proved clinically nor experimentally. Seem-

ingly, the mechanism of healing by suggestion depends on local vascular changes produced by vegetative impulses accompanying the affective changes experienced by the patient.

The nature and goal of the personal relationship established between the two persons is an aura of omnipotence and infallibility on the part of the healer, combined with submission and helplessness on the part of the patient. In all technics used by either layman or medical man, the important by-product seems to have been emotional involvement of the patient.

Melanoma and Lesions Simulating Melanoma, Andrews, G. C., and Domonkos, A. N. New York St. J. Med. 60: 391-97, 1960.

Only early diagnosis followed by appropriate therapy can reduce the high mortality rate of melanoma. The many pigmented and nonpigmented lesions simulating melanoma are difficult to diagnose accurately, either clinically or histologically. Most of these melanoma-like lesions are benign and often needless surgery is performed. The dermatologist is most competent in diagnosing the true melanoma, differentiating it from other similar growths. The junction nevi, precursors of melanoma, may appear anywhere on the body. Those on areas of constant trauma trend to become malignant. The junction nevi are the only nevi that become malignant and it is best to remove them early. The lentigo maligno (malignant freckle, melanotic freckle of Hutchinson) may occur on any site but is most frequent on the cheeks. The growth occurs in two stages. In Stage I the lesion may be from a few millimeters to several centimeters in diameter, is a mottled light brown to coal black, and is not elevated. This premalignant stage may be present for many years, without malignancy developing. A gradual enlargement should be regarded with suspicion. In Stage II, many small tumors may develop within the melanoma or the pigmented area may become indurated. Metastasis to the lymph nodes may take place. A long period of time may intervene between the premalignant and true malignant stages. Removal during the first stage may bring claims of cure even though no malignancy was present. The surgeon may even have done radical surgery, removing the regional lymph glands. A biopsy study would have prevented unnecessary surgery.

Among the lesions resembling melanoma are: (1) Pigmented seborrheic keratosis, a greasy warty excrescence on the face or trunk; cure is by simple curettage after ethyl chloride refrigeration. (2) Senile keratosis, a pigmented horny growth, occurring mostly on the face and the back of the hand. (3) Histiocytoma, frequently pigmented or mottled and usually firm and indurated, occurs most frequently on the lower extremities. (4) Pigmented basal cell epithelioma has a rolled edge with a waxy, nodular border resembling other epitheliomas but is hard to differentiate clinically from melanoma. (5) Pigmented nevi can be confused with melanoma. If irritated they become inflamed and may bleed; they may have an infected sebaceous cyst beneath and may show pseudomalignant changes. (6) Sclerosing angioma, a hard, brownish subepidermal nodule is rare; it can resemble melanoma, histiocytoma, dermatofibroma lenticulare, or myoblastoma. Diagnosis is made by histologic examination. (7) Blue nevi occur most frequently on the lateral side of the instep and cheeks; malignancy may develop. (8) Organized hematoma, induced by trauma, a black growth, is frequently mistaken for melanoma, especially if subungual. Resolution is slow; the patient may forget when the injury happened.

Melanoma occurs in various forms. Morphologic changes take place in junction nevi as malignancy develops. The lesion enlarges, becomes slightly verrucous, pigmentation increases, the border may become inflamed followed by crusting and bleeding. Ink dots (satellite pigmented macules) appearing early afford a valuable single criterion for diagnosis of melanoma. Malig-

nancy of the lymph nodes may occur without enlargement. Melanuria if detectable is a diagnostic symptom, but usually is noted after extensive metastasis. Juvenile melanoma is usually of nevi junction type in children; its rapid growth and pigmentation suggest the diagnosis. Melanotic whitlow often is diagnosed as a fungous infection due to its insidious onset. Pigmentation near or under the nail should be regarded as melanoma until biopsy proves otherwise. Subungual melanoma is frequently confused with onychomycosis or subungual hematoma. The prognosis is better in this type of melanoma, but metastasis may extend to the axilla and other areas.

Biopsy of melanoma is important in diagnosis, but dissemination is greatly feared. There is no reliable proof that metastasis is caused by biopsy. When the lesion is too large for simple excision, biopsy seems the rational procedure.

Treatment is surgical. Early diagnosis is important. Removal should be wide and deep. Local removal of juvenile melanoma is sufficient. Amputation of the digit is necessary when subungual melanoma is present. Local excision of lentigo maligna or of an old melanoma may suffice, but the decision regarding the need for radical excision depends on the individual case. Chest and skeleton x-rays and urinalysis (looking for melanin, showing dissemination) if negative, may be followed by dissection or block removal. If on the hand or foot, local removal combined with surgical dissection of the draining lymph nodes in the groin or axilla is indicated.

Thirty-one cases were followed for 5 years (1953-58). Three with juvenile melanoma had 5-year cures. Of the remaining 28 patients, 5 died (2 were not operated on —1 refused and the other was old and in poor condition); the other 18 survived for 5 years or more. Thirteen of these 18 had wide excision of the melanoma, but the lymph nodes were not removed; the remaining 5 had lymph node dissection, but none of the nodes showed evidence of melanoma. great toe for two weeks. It was tender on pressure, somewhat swollen and seemingly indurated. X-ray findings showed dense proliferation of the proximal phalanx. A biopsy with microscopic examination showed the presence of Ewing's sarcoma. The proximal phalanx was disarticulated and one-third of the metatarsal removed. Four months later the patient complained of pain in the groin and over the right femur anteriorly. The x-ray findings were negative. Approximately four months afterward, the x-ray films showed metastases to the right hip and left ribs. Palliative roentgenotherapy continued for about four months brought decrease in the size of the lesion and lessening of pain. In 10 weeks metastasis had extended to the left temeroparietal bones and the patient died.

Rheumatic Diseases

Unusual Manifestations of Gout, Rosenquist, R. C., Small C. S. and Dees, P. H. Arch. Path. 68: 1-10, 1959.

Gout is manifested particularly by deposits of urates in joint cartilages and in periarticular and perichondrial tissue, as tophi. In 5 per cent of cases the tophi become so large as to cripple the patient by making joint motion painful. The large tophi sometimes cause ulceration, and fine needles of urate crystals drain into the serous fluid. In articular cartilage the urate deposits may cause inflammation and erosion of subadjacent bone.

In addition to the metatarsophalangeal joint of the great toe, the joints of the feet, ankles, hands and wrists may be affected. Joints become enlarged, hyperplasia is produced by irritation of the membrane, and granulation tissue pannus grows about the articular cartilage, eventually destroying the articular cortex. Round cyst-like lesions form, which appear on the radiogram as punched-out areas, and are due to damage to the cortex of the bone by granulation tissue. The smaller joints are most frequently affected.

In the case presented, a 70-year-old man had joint pains for 20 years, with progres-

sive enlargement of the tophi on the joints of his hands and feet. This caused chronic ulceration and draining sinuses, so that the right fourth and fifth toes and the left fourth toe had to be amputated. He finally was unable to walk even with crutches. Radiologic studies showed extensive calcium deposits in the hands, particularly in the thumbs and on some of the metacarpophalangeal joints, and calcification in the bursal sacs of the elbows and along shafts of the bones, and large calcium deposits in the knees. Deposits were present in both feet, particularly at the ends of the metatarsal bones. Calcium filled tophi were scattered about the tarsal area and in soft tissues surrounding the foot. At autopsy, microscopic study of the tophi showed large masses of urate needles; the joint surfaces were coated with urates and tophaceous nodules protruded on joint surfaces; some tophi were partially calcified, some ossified. The kidneys showed tophaceous areas and many abscesses containing urate-crystal masses; tubules were plugged with hyalin casts.

The remarkable feature of this case was the extensive distribution of urate deposits and coating of all the joint surfaces with urates, and the large amount of calcific material in large joints as well as small joints.

Miscellaneous

The Newborn Footprints, J. Edgar Hoover. Hospitals 33: 38-41, 1959.

Skillfully taken, footprints are the one means of permanent, positive identification. The arrangement of the ridges on the fingers, palms, toes, and soles is never duplicated in another individual, not even in identical twins. Parents of identical twins who have somehow been switched for one another can get them identified by their newborn footprints. This requires skill and is done by the FBI. Footprints have advantages over fingerprints in that the surface is larger, flatter and more rigid.

Footprinting has been done in a Chicago hospital since 1915. Many hospitals today are requiring their personnel to take footprints immediately following birth of the child. Some state laws require this procedure. They are useless if done carelessly or hurriedly, so that the ridges do not show. With a little training and care, even making this a part of nurse training, the hospital can provide a good footprint that may prevent doubt and grief later. A case is related wherein a mother on coming to claim her baby, which had to remain in the hospital for some time after her discharge, said the infant was "too ugly" to be hers. Identity of the child was proved by the beaded name bracelet on its wrist, the family name on the crib, and finally by the footprints.

Footprinting should be used as an adjunct to, not substitution for, the usual hospital methods of labeling mothers and babies for easy identification. One or more permanent members of the obstetrical staff should be adequately instructed in making legible prints. Identification is then available in cases where parents question the identity of a child, in cases of kidnaping, of abandonment, or of unexpected death of a child. After a good print is made, a flat impression is made of the mother's fingers on the same document. (Detailed instruction is given by the author regarding how to make the prints.) The record of the prints should be filed in the hospital along with the name and address of the hospital, the name of the infant with sex and color, name of the mother, signature of the person taking the footprints, and any pertinent remarks in regard to identification of the baby, prints of each foot of the baby, and an impression of the index finger of the mother. If possible, the impressions should be made in the delivery room before mother or child is removed.

Footprinting of newborns is now required in all hospitals of New York City. This measure was taken after the kidnaping of an infant from a Brooklyn hospital in January 1959.

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

Georgia

The annual "Podiatrist of the Year" Award was presented to Dr. E. Dalton McGlamry of Atlanta, Georgia, by Dr. William J. Meadors, President of the Georgia Podiatry Association, for outstanding leadership in the field of podiatry in promoting postgraduate study among the podiatrists of this state. The Award was presented at the winter quarterly meeting of the Georgia Podiatry Association. Dr. McGlamry, who has practiced podiatry in Atlanta for the past 4 years and has been secretary of the state association for the past 3 years, received the Award as a result of his statewide interest in the foot health of Georgians. For the past year he has served as President of the Atlanta Podiatry Society and has been an active participant in the activities of all committees of his association.

Illinois

Science Fair Winners

Susan and Sally Hayman, daughters of Dr. William R. Hayman, Mt. Vernon, Illinois, won a high rating on their foot health project for their District Junior Academy of Science Fair in Carbondale, Illinois. The exhibit was entitled "You Mean That Could Happen to Me," and contained information on foot health rules and more detailed information on three types of cases: Metatarsalgia, Calcaneal Spur and Pes Cavus.

Minnesota

Dr. Ken Nielsen of Omaha, Nebraska, was a featured lecturer at the March quarterly meeting of the Minnesota Podiatry Association. He spoke on "Shoe Fabrication and Its Orthopedic Application," a "conventional" moulded shoe. At the business session, plans and reports regarding their

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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health insurance efforts were considered. The state society participated for the third year in the Minnesota State Fair Children's Foot Health Examinations.

Nevada

At the recent annual meeting of the Nevada Podiatry Society, the following were elected officers and appointed chairmen of committees: Dr. Alfred Siani of Las Vegas, President; Dr. Benjamin Drummer of Reno, Vice President; Dr. William A. Edwards of Reno, Secretary; Dr. Richard E. Hansen of Reno, Public Education Committee; Dr. Blair V. Anderson of Reno, Vocational Guidance Committee; Dr. Benjamin Drummer, Care of the Geriatric; Dr. William A. Edwards, National and State Insurance Relations; Dr. Benjamin Drummer, Youth Foot Health Week. Features of the meeting were discussions and reports, the state society members' activities on community programs in the aging and foot health programs for the youth of the state.

New York

A dinner in honor of Dr. John E. Green of Binghamton, New York, was held at the Sheraton Inn in Binghamton to celebrate his selection as New York's "Podiatrist of the Year." The House of Delegates has chosen Dr. Green as "Podiatrist of the Year" in recognition of his many years of service to the profession at the state and national levels.

In attendance at this dinner were a host of leading community figures, including Mayor Burns of Binghamton, the State Senator and Assemblyman. Representing the American Podiatry Association were Dr. Marvin Shapiro, immediate Past President, Dr. Benjamin C. Mullens, Vice President, and Dr. Harry Horowitz of the Board of Trustees. Dr. Francis Schwarz extended greetings to Dr. Green from the Council on Education and the New York State Board of Podiatry Examiners.

Dr. Milton Werbel, President of the New York Society, presented a plaque to Dr. Green, listing the many contributions he had made to the profession.

"Weekend in Washington"

Region Eight

[Va., W.Va., N.C., S.C., D.C.]

American Podiatry Association

Announces its Annual Scientific Meeting

to be held

November 10-11-12, 1961

Shoreham Hotel, Washington, D. C.

We extend a cordial invitation to all members of the American Podiatry Association to attend and participate.

Jerome J. Mayer, Pod.D.
President, Region 8
American Podiatry Association

Pennsylvania

"Recent surveys of the State Department of Labor and Industry show that 11 percent of disabling work injuries involve the foot," it was reported by Dr. Joseph D. Fletcher, President of the Chiropody Society of Pennsylvania, at a meeting of the Society's Committee on Labor Health Relations. In addition, he stated "that a high percentage of industrial accidents are caused by foot fatigue and could be prevented by periodic foot care."

Attending the conference, which was conducted for the purpose of reviewing accident statistics related to the feet and determining methods for improvement of foot health among industrial workers were: Dr. Paul Schneyer, Philadelphia, President-elect of the Society; Dr. Alexander Sorkin, Upper Darby; Dr. Paul Lipp, Hellertown; Dr. John Petrus, Erie; Dr. Arnold W. Newman, Philadelphia, Committee Chairman.

Northwestern Division

The regular meeting of the Northwestern Division, Chiropody Society of Pennsylvania, was highlighted by the official visitation of State President J. B. Fletcher who spoke at length on state and national chiropodial affairs. Vice President Richard Wagner presided at the meeting in the absence of President Crawford who was ill. He appointed Dr. T. P. Huels to serve as chairman of the newly created Labor Relations Committee. Drs. John Reyer, Margaret Holcapfel and Leonard Pleban were appointed to the nominating committee with elections to be held at the May meeting. Dr. Leo Lacey served as chairman for the scientific program.

Philadelphia College of Chiropody

The Association for the Philadelphia College of Chiropody met in Philadelphia on Sunday, April 9th, to approve the Constitution and Bylaws guaranteeing every member of the profession a place in the development of this unique teaching institution. Henceforth, every chiropodist-podiatrist who joins the Association will in effect become a "Founding Alumni Member," eligible to participate in the planning

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SALEM PHARMACEUTICALS **Naugatuck, Connecticut**

and execution of the program which will ultimately create an institution for training students, unlike any in the history of the profession.

Dr. Albert J. Kilberg, Camden, New Jersey, President of the Association, stressed the national scope of the proposed college as he addressed the membership. "It was disappointing to learn that our profession had lost a valued school when Temple University decided a few years ago that there no longer was need in the Philadelphia area for a training center for students of chiropody. We, of the profession, disagree with this decision, and have dedicated ourselves to creating, not just another Philadelphia teaching institution, but a College of Chiropody which reflects the most advanced thinking in our profession."

Dr. Frank H. Rubin, former President of the Temple School of Chiropody Alumni, elected in October, 1960, as President of the proposed College Board of Trustees, echoed Dr. Kilberg's remarks. "We are not content to create just another school, but rather one which provides the kind of teaching which will eventually raise the standards for our entire profession. Through our affiliation with St. Luke's and Children's Medical in Philadelphia, we have before us an opportunity unique in the history of our profession. St. Luke's medical director, James C. Giuffre, M.D., as Dean of the proposed college has guaranteed, by past accomplishment, that the new college will reflect the advanced methods of teaching for which the most noted institutions in the United States have gained prominence."

Harry B. Light, Jr., was introduced as the new Executive Director of the college. Mr. Light was the former Director of Public Relations at Abington Memorial Hospital, a suburban general hospital near Philadelphia. He has also served as a past president of the Pennsylvania Junior Chamber of Commerce. At 36, he is a recognized specialist in the field of organizational management, public relations and fund raising.

The College Board of Trustees has

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established an office at St. Luke's and Children's Medical Center, Thompson and Franklin Streets, Philadelphia 22, Pa. A monthly bulletin will be issued to all members of the Association reporting the developments of the college. Every chiropodist-podiatrist may join the Association by making application through the headquarters at St. Luke's hospital.

Dr. Rubin announced that the college will be represented at the Region Three Chiropody Science Conclave, held April 27-30 at Atlantic City, New Jersey.

St. Luke's and Children's Medical Center is the only major hospital in the Philadelphia area with an approved internship for chiropody graduates. An expected 12 graduates will enter the 1-year training in September, 1961.

Rhode Island

Dr. Edward Spindell, Orthopedic Surgeon of Providence, R. I., addressed the regular monthly meeting of the Rhode Island Podiatry Society on "An Orthopedic Approach to Surgery of the Forefoot." Following the talk, the regular business meeting of the month was convened and conducted for the remainder of the evening.

Tennessee

On March 26 the Memphis Chiropody Association presented a series of lectures by E. Dalton McGlamry of Atlanta, to the Mid-South chiropodists. Attending were podiatrists from Tennessee, Alabama, Arkansas, Kentucky and Mississippi.

Appointments

Dr. George Green, Petersburg, Virginia, has been appointed to the teaching faculty of the Medical College of Virginia as a Clinical Instructor in Podiatry in the Division of Podiatry.

Dr. Donald G. Schwartz of North Miami Beach and Dr. Seymour Z. Beiser of South Miami, Florida, have been appointed to head the Podiatry Section of the Osteopathic General Hospital being erected in North Miami Beach.

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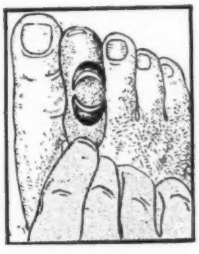

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Foot Health Center Opened on Welfare Basis by Los Angeles Podiatrists

Foot care for those who cannot afford private courses of treatment, as well as research into methods of rehabilitating many foot problems, is promised by the Foot Health Center opened to the public on March 24th by a volunteer group of Los Angeles podiatrists.

According to Arthur Monaco, D.S.C., president of the governing committee of the non-profit California Foot Health Foundation, the center will diagnose and treat those who need its services "from infants through senior citizens." Fees will be based entirely upon the patient's ability to pay and in many cases these will be free.

The Center will carry on extensive research projects, particularly in the use of physical electronic means – heat, hydromassage, diathermy and especially the new ultrasonics–aimed at remedying a number of common but resistive conditions of the foot and leg.

An array of such equipment has been made available free as a public service to the Center by the Birtcher Corporation, Los Angeles manufacturer of medical electronic equipment.

The Foot Health Center occupies quarters at 3307 South Grand Avenue in Los Angeles. It has been endorsed by the California Podiatry Association, Southern Division. In addition to Dr. Monaco, who is a practicing podiatrist in Panorama City, the Center's governing committee consists of Robert Barnes, D.S.C., Burbank, vice president; Alfrena Matchett, Beverly Hills, secretary and Sidney Bob, D.S.C., Southwest Los Angeles, member. Many podiatrists throughout the Los Angeles County area have pledged time to the Center and its various treatment and research projects.

One of the first of these will be to survey the condition of feet of grade school children. Working in teams either at the Center or in the local area, the podiatrists will attempt to locate and treat foot problems existing among the youngsters. This project will be done strictly as a public service. There will be no charge either to the parents or the schools.

The Center will set aside time and facilities for a high level of research. One promising research project will be to determine the usefulness of ultrasonics in the treatment of disabling foot conditions.

The Foot Health Center presently is open Monday, Wednesday and Friday from 1:00 to 4:00 p.m.; Tuesday and Thursday from 10:00 a.m. to 1:00 p.m.; Saturday from 1:00 to 4:00 p.m.; and Wednesday evening from 6:00 to 9:00 p.m.

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Women's Auxiliary Message

The Valuable Man

All of us at one time or another have heard complaints about our local, state and national organization. Some of them are probably justifiable, but usually the one who complains the most is the one who does the least. It reminds me of a poem which appeared in my husband's Rotary paper.

Some fellows stay right in the rut.
While others head the throng.
All men may be born equal but
They don't stay that way long.
There's many a man with a gallant air,
Goes galloping to the fray:
But the valuable man is the man who's there
When the smoke has cleared away.
Some don't "get nuthin' out of life,"
But when their whines begin,
We often can remind them that
They don't "put nuthin' in."

Mrs. Cleotha Parham, President

—— Legal and Legislative ——

Tennessee

Recent legislation in Tennessee outlaws the use of fluoroscopic X-ray for the fitting of shoes.

troubled toes! . . . give them a chance to breathe . . .

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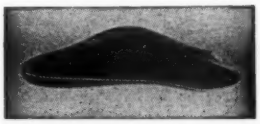
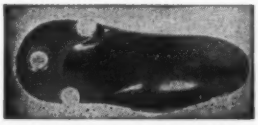


known for



Their outstanding, skilled craftsmanship in the appliance of old-fashion and modern hand-made foot appliances for any kinds of deformity as well as Balance Inlays. Levy and Sansone Molds, Celastic, and arches of oak sole leather with blue tempered steel springs; also flexible type of supports of cork and rubber.

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Communications

The Explosive Educational Problem

Perhaps I can best be described as a "doom and gloom" person. I have many misgivings about the solution of our college problem and its resulting deleterious effects on the future of our profession. As a matter of fact, I wonder if there is a future, taking the long-range view, for the profession of podiatry-chiropody.

The number of students in all of our colleges is at an increasingly lower level. The financial plight of the colleges is a matter of deep concern to all of us, this, in spite of a heroic effort on the part of our college administrators to put a good face on rather grandiose plans for future expansion. In one man's opinion, this is the stuff of which dreams are made. Frankly, I think we are in one heck of a fix.

With the number of graduates shrinking, our membership totals in the A.P.A. will move at a declining ratio. The national association, brimfull of new and exciting programs, must certainly run into a dead-end situation should the level of new members start declining in a downward spiral.

Can anything be done to retrieve what appears to be almost a hopeless problem? A start has already been made. The Fund for the Advancement of Podiatry-Chiropody Education reported in the February issue of the A.P.A. Journal that it has approximately $100,000 collected and pledged, a magnificent beginning spark-plugged by the brilliant leadership of Dr. Harry Horowitz, president of the Fund. However, we must go on from here.

At hand, we are faced with the necessity of enrolling more students in the colleges and supplying funds for the maintenance and normal expansion of our schools. Money, and a goodly share of it, will be required for many years to come in order for the profession to win its battle for survival. For the present there is one source and one source only. Naturally, it is you and I, and every other member of the profession. No outside Fund or Foundation can be tapped without a backlog of solid achievement by the potential recipient. Our current drive, through the Fund for the Advancement of Podiatry Education and the forthcoming report of the Selden Commission, should bolster our position.

Let's get down to cases. Every last man of us recognizes the dire urgency of the ed-

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ucational problem and all that it means in terms of whither Podiatry. There is only one fair and equitable approach. A tax, yes, a tax on every practitioner. Our stake is the important one.

I propose that the members of the 1961 House of Delegates meeting in Florida impose a $10 tax on each member. The monies collected are to be in a separately maintained education fund and never to be used for any other purpose. Through the years the amount of money will grow and assume sizable proportions.

Thus, the problem is being met head on. We are all involved in a solution that affects each of us. The Association will not have to plead, beg or cajole. We will all carry a fair share of the load. The Federal government needs funds for defense and survival. An income tax is imposed for that purpose. Podiatry-Chiropody can do no less. Maybe the projected tax should be higher. I don't think so. The amount stipulated is modest and can go a long way in reaching our goal.

Milton Wolfson, Pod.D., Past President, New York Podiatry Society

To the Editor:

After many long years of practice I thought I had heard everything a patient could tell me, but now I have had an experience more unique than any other I can recall.

Into our office for an examination of his feet came a Mr. A. C. Before removing his footwear he told us a story that was a bit queer, to say the least. He had never had any trouble with his feet but on walking some distance he developed a pain in his back. "I have always laced my shoes loosely," he said, "but one day, for no reason whatever and without premeditation, I pulled the strings tight. Since then my back pain has stopped, no matter how far I walk. I have had a wonderful feeling of well-being. I feel good all over. I can stand and walk without any pain in my back."

Our reactions to this were twofold: first there was the impulse to tell the man to continue his tight lacing and get the heck out of here; then our professional disciplines took control and we gave him the examination he came in for.

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originator of foot balance inlays is directed
in all its endeavors to accomplish this result

His feet were strong and well arched, completely free from the common lesions, circulation good, reflexes normal. There was no lordosis that he was aware of nor other defect that might have a bearing on the matter.

Turning our attention to posture and gait we found only minor suggestions to offer. Then, having paid our fee, Mr. A. C. went out smiling and "feeling good all over."

Out of this case one hard and undeniable fact emerges. It was the tight lacing of his shoes and *nothing else* that stopped this man's backache. He had discovered by sheer accident and with complete ignorance of the rationale back of it what podiatrists have been preaching for a hundred years: that tightly laced shoes (not constrictively) hold the foot firmly in position, give it a corsetlike support through the arch, allow more freedom in the forefoot and aid the whole mechanism to function more adequately.

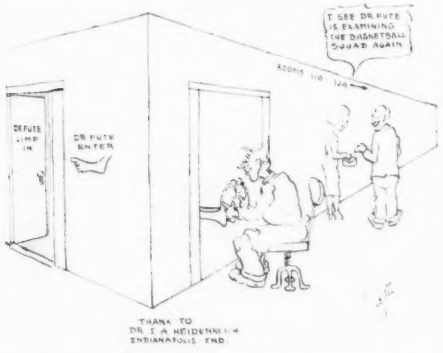
Let us never lose sight of the therapeutic value of the carefully selected, correctly fitted and properly worn shoe.

A. O. Penney, Washington, D. C.

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. **A.O.P.**

One of General Mark Clark's officer-friends once was wondering how old the General was. He cabled to the Pentagon: "How old Mark Clark?" Came the reply: "He fine, how you?"


I SEE DR FUTE IS EXAMINING THE BASKETBALL SQUAD AGAIN
DR FUTE LIMPS IN
DR FUTE ENTERS
THANK TO DR. I. A. HEIDENHEIM INDIANAPOLIS IND

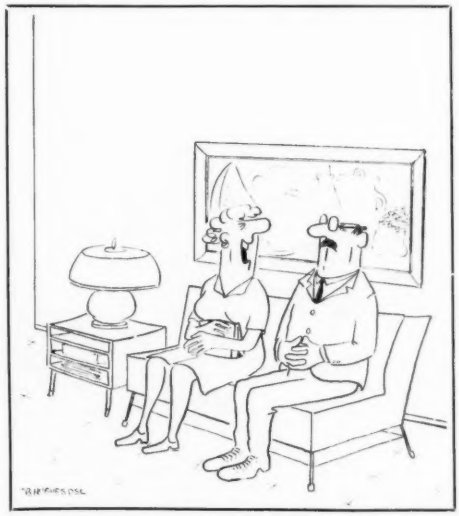
A minister, returning to a country town where he had served a church many years before, spied a farmer whom he had married, working in a field, and stopped for a chat. During the conversation, he spoke of how the bride had had the whole church upset because she was so late. "My goodness!" he exclaimed, "you certainly got a fright that day."

"Yes," growled the farmer, "and I still have her."

A gentleman is a man who holds the door open while his wife carries in the groceries.

These new lipsticks in different flavors may be all right but what was wrong with the good old days when you kissed a girl and all you tasted was girl?

DR. POD **By Bob Hughes**



"Oh there's nothing wrong with my feet, but I have this cute little insurance policy!"

Dates to Remember

EVENTS

Youth Fitness Week

April 30-May 6, 1961. Sponsored by President's Council on Youth Fitness.

Foot Health Week

May 14-20, 1961. Sponsored by American Foot Health Foundation.

Youth Foot Care Week

Oct. 15-21, 1961. Sponsored by American Foot Health Foundation.

MEETINGS

American Podiatry Association
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
Chicopee, Mass., Oct. 14-16, 1961
Schine Inn
Dr. A. Joseph O'Rourke, Gen. Mgr.
176 Academy Ave., Providence, R. I.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
Columbus, Ohio, May 18-20, 1961
Deshler-Hilton Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Drs. Stewart E. Reed and Ralph C. Kirkwood
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Vance A. McNish, Convention Chairman
1218 Selling Bldg., Portland 5, Ore.

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Washington, D. C., Nov. 10-12, 1961
Shoreham Hotel
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Birmingham, Ala., Oct. 20-22, 1961
Bankhead Hotel
Dr. Stanley Frank, Secretary
1250 Forrest Ave.
Gadsden, Ala.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Fort Worth, Texas, June 14-17, 1961
Hotel Texas
16th Southwestern Chiropody Congress
44th Annual Convention of Texas Society
Dr. Joseph R. Ordile, 111 Professional Bldg.,
Ft. Worth 4, Tex.

Region Twelve
(Ariz., Cal., Nev., Utah)
San Francisco, Calif., May 24-28, 1961.
Jack Tar Hotel
David Y. Chan
2107 Van Ness Ave., San Francisco, Calif.

International Union of Podology
Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

Canadian Podiatry Association
Vancouver, B. C., Aug. 18-20, 1961
University of B. C.
Dr. N. Mathews, Chairman
624 - 6th St., New Westminster, B. C., Canada

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STATE & REGIONAL MEETINGS

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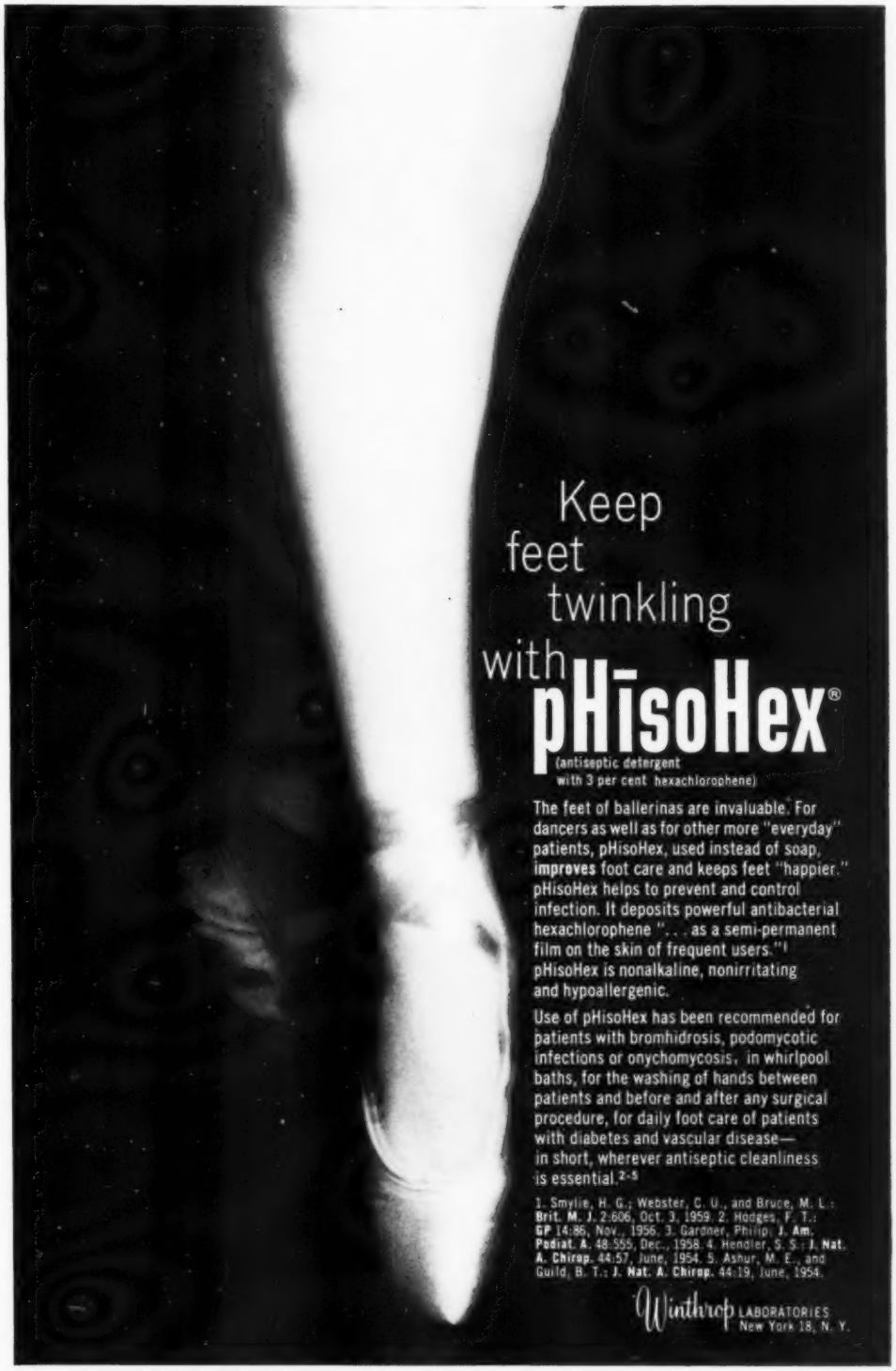
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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:606, Oct. 3, 1959. 2. Hodges, F. T.: **GP** 14:86, Nov., 1956. 3. Gardner, Philip: **J. Am. Podiat. A.** 48:555, Dec., 1958. 4. Hendler, S. S.: **J. Nat. A. Chirop.** 44:57, June, 1954. 5. Ashur, M. E., and Guild, B. T.: **J. Nat. A. Chirop.** 44:19, June, 1954.
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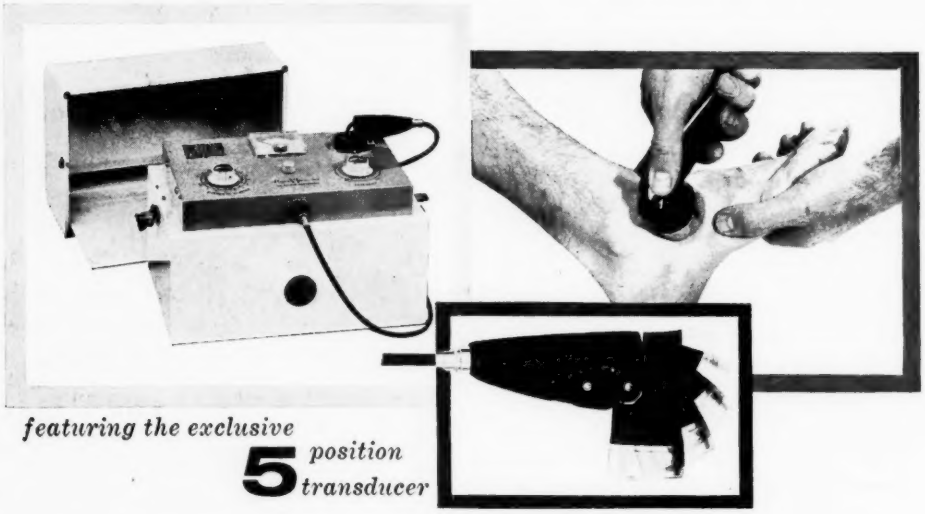

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